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EMPLOYEE BENEFITS OVERVIEW

The City is pleased to provide you with an extensive benefits program. It includes insurance programs and other health, financial, and professional benefits. These benefit programs are listed below and described in this handbook. Complete details on each individual benefit plan can be found in each insurance provider's Evidence of Coverage (EOC), Summary Plan Description (SPD), brochure, policy certificate, or contract that applies to each specific benefit. The written policy, plan, or contract must be consulted to determine the terms and conditions of coverage for each specific benefit plan.

HEALTH INSURANCE

Five health plan choices are available:

- Kaiser*
- Blue Shield (HMO)*
- Blue Shield (Point-of-Service)*
- Blue Shield (PPO)*
- Health-In-Lieu (available if you have other alternate health insurance)

DENTAL INSURANCE

Three dental plan choices are available:

- Delta Dental Plan (PPO)*
- DeltaCare/PMI Plan (HMO)*
- Dental-In-Lieu (available if you have other alternate dental insurance)

VISION CARE INSURANCE

Two voluntary vision plan choices are available:

- Cole Managed Vision*
- Vision Service Plan (VSP)*

** The City's Health, Dental, and Vision plan premiums are deducted from your paycheck pre-tax (Exception: A pro-rated portion of the monthly health premium which is attributable to domestic partners is considered taxable imputed income by the IRS. Please refer to the City's <u>Affidavit of Domestic Partnership</u> form for a more complete description of this tax issue.).*

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The City's Employee Assistance Program (EAP) offered through Managed Health Network has been established to offer free, confidential counseling to benefited employees and their dependents. Services cover a wide range of personal issues including marital, family, interpersonal, emotional, and drug abuse issues. In addition, a number of life management services are available to help you with child & elder care, legal, financial, credit, IRS, and retirement issues.

FLEXIBLE SPENDING ACCOUNTS (FSA's)

These pre-tax programs administered by AFLAC are convenient ways for City employees to apply pre-tax money toward unreimbursed medical or dependent care expenses.

- **Medical Reimbursement Account (MRA)** – This program is designed to help you pay for healthcare expenses that are not covered by your health plan, dental plan, etc.

- **Dependent Care Assistance Program (DCAP)** – this program is designed to help you pay for the costs of caring for your dependents while you work.

By using a Medical Reimbursement Account (MRA) or the Dependent Care Assistance Program (DCAP), your out-of-pocket expenses can be paid from a trust account funded with pre-tax deductions from your paycheck. This reduces your taxable income so you will pay less in taxes and have more money to spend and save.

LIFE INSURANCE

Basic, Supplemental, and Dependent life insurance coverage, including accidental death & dismemberment coverage (AD&D), is provided through the City's group policy with The Standard Insurance Company.

LONG TERM DISABILITY (LTD) INSURANCE

Optional long-term disability (LTD) insurance is provided through the City's group policy with The Standard Insurance Company.

Employees should note that the City does not contribute to State Disability Insurance (SDI). City of San Jose employees are not covered under California State Disability Insurance programs. The City's LTD insurance policy covers employees up to two-thirds of their gross monthly salary if they become unable to work due to a work or non-work related disabilities. This coverage is in-lieu of SDI and is 100% employee-paid.

PERSONAL ACCIDENT INSURANCE

This optional benefit, provided through CIGNA Group Insurance, provides additional single and family coverage for accidental death and dismemberment (AD&D) in addition to the AD&D Coverage provided under the City's life insurance group policy.

LONG TERM CARE (LTC) INSURANCE

Optional long term care insurance is provided through Prudential Insurance Company of America. This insurance covers expenses related to nursing home care, residential care facility care, and community and home-based care. It is designed to help alleviate the financial burdens of participants who suffer the need to utilize such services. All benefited employees and their spouses, domestic partners, parents, parents-in-law, grandparents, or grandparents-in-law are eligible to apply under the City's group policy.

DEFERRED COMPENSATION PLAN

This pre-tax program is a convenient way for City employees to save money for retirement. Money is deducted from your payroll check before taxes are taken out (thus reducing your taxable income) and is invested in available plan options selected by you. This plan was established under Section 457 of the IRS code. Plan providers include ICMA Retirement Corporation and ING Financial Advisors.

OTHER CITY BENEFITS AND PROGRAMS

- **Paid and Unpaid Absence Benefits**
- **Workers' Compensation Benefits**
- **Personal & Professional Development Programs**
- **Alternative Work Schedules**
- **Commute Assistance Program**
- **Personal Banking Services**

CITY OF SAN JOSE
CAPITAL OF SILICON VALLEY

Memorandum

TO: **All Employees**

FROM: **Employee Services, Employee Benefits**

SUBJECT: **PRIVACY NOTICE EFFECTIVE APRIL 14, 2003 REVISED MARCH 19, 2004**

DATE: **March 19, 2004**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The City of San Jose is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your Protected Health Information (PHI) and to provide you with this notice of our privacy practices and legal duties. The City is required to abide by the terms of this notice. The City reserves the right to change the terms of this notice and to make any new provisions effective to all of the PHI that we maintain about you. If we revise this notice, we will provide you with a revised notice within sixty (60) days.

PROTECTED HEALTH INFORMATION

PHI includes all individually identifiable health information transmitted or maintained by the City. PHI includes, but is not limited to,

- Your name
- Social Security number / member ID
- Demographic information (such as gender and date of birth)

PERMISSIBLE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We may use and disclose your PHI for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization.

Health Care Operations – The City may use or disclose PHI to administer benefits and as necessary to provide coverage and services to you. Health Care Operations include such activities as:

- Customer service and resolution of complaints
- Activities relating to creating or renewing insurance contracts
- Enrollment information

Health Care Payment - The City may use or disclose PHI in order to pay for your covered health expenses such as making payments to other parties, including a health plan or provider.

Treatment – The City may use or disclose your PHI to determine eligibility for services.

Disclosure to Others – The City may also disclose PHI to others under a variety of circumstances when:

- Required by federal, state or local law
- Soliciting premium bids from other plans
- Required by court actions or law enforcement purposes, or
- Complying with laws related to worker's compensation

YOUR RIGHTS REGARDING YOUR P.H.I.

You have a right to know how the City may use or disclose your PHI. This notice informs you of those uses and disclosures. You have the right to make certain requests, **in writing**, to the City's Privacy Officer (listed at the end of this document) regarding your PHI. You may:

- Review and obtain a copy of your PHI. A fee may be charged for producing and mailing your requested information, if applicable.
- Request to amend your PHI if you believe that information is incomplete or inaccurate. If your request is denied, we will notify you in writing. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.
- Request that the City restrict certain uses and disclosures of your PHI. However, the City is not required to agree to your request.
- Request to receive an accounting of certain disclosures of your PHI.
- Request to receive communications in a certain way or at a certain location (e.g. a designated mail or e-mail address or phone number).
- Request a paper copy of this notice at any time, even if you received this notice previously.

Authorization to Use or Disclose Health Information – All other uses or disclosures of your PHI will be made only with your written permission, and you may revoke that permission in writing at any time.

Copy of Privacy Notice – You have the right to get a copy of this notice by e-mail. A copy of this Privacy Notice is also posted on the City's Intranet site under Employee Services/Benefits/Privacy Notice.

Complaints – If you believe that your privacy rights have been violated, you may submit a written complaint (using the Health Information Privacy Complaint form posted on the City's Intranet site under Employee Services, Benefits) to the City's Privacy Officer: Jay Castellano, Privacy Officer, City of San José, Employee Services, 200 E. Santa Clara St., San Jose, CA 95113.

You may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102. You will not be retaliated against for filing a complaint.

Contact us – If you have questions about this notice or your PHI, contact Employee Benefits at 408-535-1285.

ENROLLMENT & DEPENDENT ELIGIBILITY

It is important to recognize your responsibilities for benefit plan enrollment. The City makes the benefit programs available, but you must enroll to receive coverage for yourself and your eligible family members.

New Enrollment Time Constraints

Many of the City's benefits have a 30-day window of opportunity in which you may enroll and/or be guaranteed coverage. For these plans and policies, you must enroll or apply within the first 30 days of your employment or benefits eligibility. Otherwise, you may be required to wait for the City's annual open enrollment period in November to enroll, or you may lose an opportunity for guaranteed coverage (some insurance policies require medical underwriting information for late applications). These limitations usually apply to new dependents as well.

Default Enrollment

<u>Health & Dental</u> – If you do not actively enroll in one of the City's Health or Dental plan options within the 30-day time limit, you will be enrolled by default in the Kaiser health plan and DeltaCare/PMI HMO dental plan (full-time employees only). Your dependents will <u>not</u> be enrolled. You may <u>not</u> change your health or dental plan, nor enroll any eligible dependents until the next open enrollment period in November. Open Enrollment changes will become effective January 1 of the following year.

<u>EAP & Basic Life Insurance</u> – Benefited employees will be automatically enrolled in the Employee Assistance Program and for Basic Life Insurance coverage when they become eligible for these benefits. Eligible employees must waive these benefits in order to forego default enrollment. These benefits are 100% City-paid.

Eligible Dependents

For most of the City's benefit plans, dependents are defined as your spouse, domestic partner, and unmarried children (including adopted children, guardianships, stepchildren, and children of your domestic partner). Unmarried child dependents under the age of 19 are automatically eligible for benefits as your dependents; however, children between 19 and 24 years of age may qualify as dependents only if they are full-time students. Grandchildren are not considered eligible dependents unless the employee can furnish proof of legal guardianship.

Child dependents, age 19 and older, who are totally disabled, are eligible for benefits if they are incapable of self-sustaining employment because of mental retardation or physical disability that occurred prior to reaching age 19, and are chiefly dependent upon the employee for support and maintenance. In order to continue benefits coverage for your disabled child over age 19, you must contact your health care provider and follow their procedure for approving a dependent's disabled status. Proof of continuing disability and dependency may be required by the health plan, but not more frequently than once per plan year.

New Dependents

If you get married, have a child, adopt a child, or become legal guardian of a child during your City employment, review your current benefit enrollments immediately**. You must enroll new**

dependents within 30 days from the date of marriage, domestic partnership, birth, or other change in status in order to make mid-year plan changes.

To enroll a new dependent, submit a copy of the marriage certificate (for spouse dependent), Affidavit of Domestic Partnership or State Certificate (for domestic partner dependent) and/or a birth certificate (for child dependents) to Employee Benefits (City Hall Wing, 2nd Floor, Employee Services, 535-1285) along with the appropriate benefit enrollment forms.

You will be required to produce birth certificates or adoption papers to add dependent children, and a marriage certificate to add a spouse, within the initial 30 days of hire or benefits eligibility. If your marriage certificate or children's birth certificates are not immediately available, you may request a 30-day extension by completing a *Request to Provide Dependent Coverage* form within that initial 30 days. You may then submit the required documents as soon as they become available. Failure to provide required documents within the 30-day extension period may result in disqualification of your dependents.

The *Request to Provide Dependent Coverage* form is available in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Domestic Partners

The City of San José recognizes two levels of Domestic Partnerships:

1. Unmarried same-sex or opposite-sex partnerships meeting the criteria of domestic partnership as defined by the State of California or as indicated on the City of San José Affidavit of Domestic Partnership. Benefit eligibility for this Domestic Partner relationship is explained in the paragraph on "***Domestic Partner Benefits***" below.
2. Same-sex marriages certified by other jurisdictions for benefits purposes. Benefit eligibility for this relationship is explained in the paragraph on "***Same-Sex Marriage***" below.

Domestic Partner Benefits - Domestic Partners, and/or children of a domestic partner, may be added within 30 days of the beginning of a domestic partnership or state registration, during Open Enrollment or within the first 30 days of your date of hire or benefits eligibility. In order to enroll a domestic partner and/or children of your domestic partner, you and your partner must complete and return an *Affidavit of Domestic Partnership* or provide a Certificate of Domestic Partnership issued by the State of California to Employee Benefits (City Hall Wing, 2nd Floor, 535-1285) along with the appropriate benefit enrollment forms.

The *Affidavit of Domestic Partnership* and other forms are available in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Same-Sex Marriage Benefits – The City of San José recognizes same-sex marriages certified by other jurisdictions for benefits purposes. Employees in a same-sex marriage can enroll their new spouse, and children of their new spouse, under their benefit plans within the first 30 days of marriage.

Annual Open Enrollment Period

Open enrollment is held every year in November. At this time, employees may change health, dental, or vision plan providers, add eligible dependents to their benefit plans, provide status verifications for over-age FT students, and enroll in the City's pre-tax MRA and DCAP accounts for the following calendar year. All plan changes made during open enrollment become effective on January 1 of the following year.

If you did not enroll new dependents in your health, dental, or vision care insurance plans within 30 days of a qualifying event (marriage, birth, adoption, or guardianship), you may enroll them during the open enrollment period.

Annual Student Verification Period

Employees with dependents age 19-23 who are full time students (i.e. enrolled in 12 or more semester/quarter units in an accredited college or university, or enrolled in a technical, trade or occupational school on a full-time basis as defined by the school) must provide evidence of full time status for the fall or spring term to continue carrying these dependents under their benefit plans. Verifications must be provided by the last day of open enrollment each year in order to maintain coverage in the following calendar year. Dependent students without verification will remain covered until the end of the current calendar year and dropped effective January 1 of the following year.

Health, Dental, and Vision coverage for child dependents turning 19 will be carried through to the end of the calendar year in which they turn 19. Child dependents turning 24 will only be carried through the end of the month in which they turn 24, after which coverage will be terminated (see the *COBRA Coverage* section of this handbook for benefit continuation rights).

Beneficiary Designations

Many benefit programs have survivorship or beneficiary clauses, and you will be asked to designate beneficiaries by name and by Social Security number during your initial enrollment. Always review your dependent coverages and beneficiary designations soon after any major life change (marriage, divorce, birth or death in the family). Beneficiary changes can be made at any time by submitting a new *Beneficiary Designation* form to Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

PREMIUM CONTRIBUTIONS

Because insurance premium rates change often, they are not included in this guide. You can obtain information about rates (premium costs) and regular contributions at any time by picking up Health, Dental, or Vision rate sheets in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285). Rate information is also available on the Employee Services Department's Intranet site: www.csj.gov.

The City contributes to a number of benefits including Health, Dental, Vision, Employee Assistance Program (EAP), and Life Insurance. The contribution level for these benefits is subject to each union's Memorandum of Agreement (MOA). Please refer to your MOA for specific cost sharing arrangements associated with your classification and union affiliation.

Generally speaking, the percentage of the Health and Dental plan premiums the City pays for you is based on your Standard Hours (the number of hours you are regularly scheduled to work each week). If you hold a benefited position, the City will pay the portion of your health and dental insurance premiums shown below:

Standard Hours	Amount City Will Pay
Full-Time: 40 hours/week	Based on MOA
Part-Time: 30–39 hours/week	City pays 75% of its FT contribution
Part-Time: 25–29 hours/week	City pays 62.5% of its FT contribution
Part-Time: 20–24 hours/week	City pays 50% of its FT contribution

The City's contributions for other benefits may vary. Please consult your union's Memorandum of Agreement (MOA) for cost sharing information. Current rate information is available from Employee Benefits (City Hall Wing, 2nd Floor, 535-1285).

HEALTH INSURANCE

The City of San Jose currently offers a choice of four health insurance plans: Kaiser, Blue Shield HMO, Blue Shield POS and Blue Shield PPO. A Health-in-Lieu plan is available for employees with alternate group health coverage. A brief summary of each health plan is presented here. Plan information and rate sheets are available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of five City health plans.

Cost

Your contribution and the City's contribution are subject to change each year in January in accordance with contract renewals. The percentage that you pay of the entire monthly premium is determined by your *Memorandum of Agreement (MOA)*. Information on current premium rates is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The four health insurance plans are pre-tax benefits. This means your premiums are paid before withholding taxes are taken from your paycheck. Consequently, your health insurance premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison and provider information packets for each health insurance plan which describes their respective services. To select your health plan, please carefully read these materials. Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if you are adding a domestic partner and/or proof of alternate coverage if you are enrolling in the Health In-Lieu plan.

2. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Add Dependents* form will be required if you are adding a spouse, domestic partner, or child dependent(s).

Please Note: To enroll in one of the City's health insurance plans, you **must** live or work in that plan's designated Service Area. If you and/or your dependents live outside of the Service Area for a specific plan, you will need to travel into the service area to access most services besides emergency services. See Blue Shield's PPO Health Plan later in this section.

Default Enrollment

If you do not enroll on-line or turn in your *Health, Dental, & Vision Enrollment/Change Form* within your first thirty (30) days of employment, you will be enrolled in the Kaiser Health Plan (unless you complete a *Request to Waive Insurance* form available in the Employee Services Department). Your dependents will not be enrolled. You will have to wait for the annual open enrollment period in November to change to another plan or to enroll your dependents. Any change made at open enrollment will not take effect until January 1 of the following year.

When Does Coverage Begin?

You and your eligible dependents may use your selected health plan starting on the first day of the month following the date of your enrollment. You will be given the date on which your coverage takes effect when you enroll on-line or when Employee Benefits receives your completed enrollment form.

Coordination of Benefits

If you or your dependents are entitled to health benefits under more than one health plan, please consult your respective plans to inquire about Coordination of Benefits. Sometimes one plan will pay a percentage of the cost not covered by another plan. Benefits are usually calculated so that the total payments by all plans involved will not be greater than the total cost of the covered services received.

Women's Health and Cancer Rights Act of 1998

Your health plan, as required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, please consult your plan's *Evidence of Coverage*.

Health Insurance Claims Complaint/Appeal Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the health insurance company within sixty (60) days of the denial.

AFTER you have contacted your health insurance company to file an appeal and utilize the plan's grievance process, you may file a complaint against your health plan with the California Department of Managed Health Care (DMHC). The DMHC requires that your health plan provider advise their members of the following:

> *The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.*

When Coverage Terminates

Health coverage for you or your dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for you and your qualified dependents.

HEALTH PLAN OPTIONS

KAISER PERMANENTE OF NORTHERN CALIFORNIA (GROUP # 887)

Kaiser is a prepaid group practice health maintenance organization that provides direct services only through Kaiser Foundation hospitals, medical offices, and physicians. Kaiser is not considered an HMO, but they do provide managed care. Each Kaiser member is encouraged to choose his or her personal physician from a list of available staff.

Summary Benefit Information

- There is no annual deductible, no per-visit cost, and prescription drugs are covered at a $5 Co-pay per prescription at Kaiser pharmacies only. Prescriptions are subject to a managed formulary.
- You must live or work in the Kaiser Service Area to enroll. Please contact Kaiser's Customer Service Center to confirm that you are currently living in a Kaiser Service Area.
- Kaiser will send new enrollees a member card within 10-14 days after enrollment. Please cite your name, social security number, and the City's group number (887) when trying to access coverage prior to receiving your membership card.

Contact Kaiser Permanente

Kaiser's Customer Service Center (1-800-464-4000) can assist you with questions regarding claims, eligibility, usage, and network. Kaiser also provides member-specific information on-line, including provider lists and locations, through their Internet website.

Contact Kaiser by phone:	1-800-464-4000
Or visit their web site:	www.kaiserpermanente.org/ca/csjemployees

BLUE SHIELD OF CALIFORNIA HMO PLAN (GROUP #H11186)

Blue Shield offers a health maintenance organization (HMO) plan for employees who live or work within Blue Shield's available Service Areas. All enrollees in the Blue Shield HMO plan must select a Primary Care Physician (PCP) from within the Blue Shield HMO network.

Summary Benefit Information

- Blue Shield HMO is a prepaid direct service health insurance plan that provides services from contracting medical groups and hospitals in California.
- All services must be accessed through Blue Shield HMO participating providers. All enrollees must select a Primary Care Physician (PCP). Different family members may choose different PCPs. All specialist services (except OB/GYN) require referral by the designated PCP. Your OB/GYN must be in the same medical group as your PCP. You may self-refer to a specialist within your PCP's medical group for a consultation visit for a $30 co-pay. All hospitalizations require prior authorization by Blue Shield.
- There is no annual deductible. Generally, the cost per office visit is $5, and prescriptions are filled by Blue Shield-member pharmacies with $5 co-payment for generic, $10 for name brand, and $15 for non-formulary prescriptions. Prescriptions are subject to a managed formulary.
- You must live or work in a Blue Shield HMO Service Area to enroll. Please contact Blue Shield's Customer Service Center to confirm that you live in a Blue Shield HMO Service Area
- Blue Shield will send new enrollees a member card within 10-14 days after enrollment. Please cite your name, social security number, and the City's group number (H11186) when trying to access coverage prior to receiving your membership card.

Contact Blue Shield

Blue Shield's Customer Service Center (1-800-837-4481) can assist you with questions regarding eligibility, usage, and network. You may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone: 1-800-837-4481

Or visit their web site: www.mylifepath.com

BLUE SHIELD OF CALIFORNIA POINT-OF-SERVICE (POS) PLAN (GROUP # MH0161)

Blue Shield offers a 3-tiered Point-Of-Service (POS) plan for employees who live or work within Blue Shield's available Service Areas. All enrollees in the POS plan must select a Primary Care Physician (PCP) from within the Blue Shield HMO network (Tier 1); however, coverage is available outside the HMO network as well.

Summary Benefit Information

- HMO (Tier 1) – This tier offers the maximum coverage under this plan at minimum cost. All services are coordinated through the member's PCP (in the Blue Shield HMO network). Co-pays usually amount to $5 for office visits and services. No deductibles apply when accessing services through this tier. Preventative services must be accessed through this tier for coverage.
- PPO (Tier 2) – This tier provides medically necessary services at discounted rates from participating Blue Shield preferred providers (PPO network physicians). Services must be accessed through the Blue Shield PPO network. Members are responsible for Tier 2 deductibles and co-pays. Co-pays typically include $10 co-payments for office visits and outpatient services and 10% co-payments for hospital benefits. Preventative services are not covered under this tier.
- Out-of-Network (Tier 3) – This tier allows plan members to access services through any physician or hospital (outside the HMO and PPO networks). Members are responsible for Tier 3 deductibles and co-payments. Blue Shield will cover up to 70% of their allowable amounts for services. Members are responsible for 30% of the Blue Shield allowable amounts in addition to any uncovered balance billing if applicable. Preventative services are not covered under this tier.
- Prescriptions – $5 co-pay for generics or $10 co-pay for name brands. Prescriptions are available at Blue Shield member pharmacies and subject to a closed formulary.
- Deductibles – Under tiers 2 and 3, a $100 annual deductible applies for each participant per year ($200 maximum deductible per family per year).
- Service Areas – You must live or work in a Blue Shield HMO Service Area to enroll. Please contact Blue Shield's Customer Service Center to confirm that you live in a Blue Shield HMO Service Area.
- Blue Shield will send new enrollees a member card within 10-14 days after enrollment. Please cite your name, social security number, and the City's group number (MH0161) when trying to access coverage prior to receiving your membership card.

Contact Blue Shield of California

Blue Shield Customer Service (1-800-837-4481) can assist you with questions regarding claims, eligibility, and network. You may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone:	1-800-837-4481
Or visit their web site:	www.mylifepath.com

BLUE SHIELD OF CALIFORNIA PPO PLAN (GROUP # 975567)

If you or your covered dependents live outside of the designed health plan Service Areas, you may select the PPO plan from Blue Shield. Rates for the Blue Shield PPO plan are the same as the Point-of-Service plan rates.

No primary care physician referrals are required. Services may be accessed directly through either Blue Shield's Preferred Provider Organization (PPO) network of participating physicians or facilities, or out-of-network altogether.

Please note that some services are not covered when accessed through non-Blue Shield participating physicians or facilities. Please consult your Evidence of Coverage or contact Blue Shield to confirm coverage for out-of-network services.

Summary Benefit Information

- PPO Benefits
  - $100 Deductible per year ($200 max. deductible per family per year)
  - $10 Office Visit Co-pay
  - 10% Co-pays for most services (based on Blue Shield *Allowable Amount*)
- Out-of-Network (OON) Benefits
  - $100 Deductible per year ($200 max. deductible per family per year)
  - Co-pay = 30% of Blue Shield's *Allowable Amount*. Charges above and beyond the *Allowable Amount* are the participant's responsibility.
  - Preventive & Family Planning services not covered out-of-network
- Annual Copay Maximum – $2,000 Calendar Year Co-pay maximum per person (PPO & OON)
- Prescriptions – $5 co-pay for generics or a $10 co-pay for name brands. Prescriptions are available at Blue Shield member pharmacies and subject to a closed formulary.

The PPO plan generally pays 90% of the cost for services you access through Blue Shield PPO doctors or hospitals. If you use the Out-of-Network component of the PPO plan, the plan will pay 70% of Blue Shield's allowable amount for services received by a non-PPO doctor or hospital (balance billing may apply).

More detailed plan information is available upon request from Employee Benefits, 535-1285.

Contact Blue Shield of California

Blue Shield's Customer Service Center (1-800-837-4481) can assist you with questions regarding claims, eligibility, usage, and network. You may also find personalized information by logging on to Blue Shield's website. If you have already enrolled in Blue Shield, a pre-set User ID and Password will be available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact Blue Shield by phone:	1-800-837-4481
Or visit their web site:	wwwmylifepath.com

HEALTH IN-LIEU PLAN

The City of San Jose's Health In-Lieu plan provides eligible employees a cash incentive to forego coverage under one of the City's available health plans when employees can furnish proof of alternate health coverage.

Eligibility

Full-time and Reduced Work Week (35+ hours per week) employees who have alternate health insurance coverage through another group health plan may participate in the Health In-Lieu plan, or may choose health coverage under one of the three health plans described above.

In-Lieu Payments

Participants in the Health In-Lieu plan receive a cash payment of 50% of the City's contribution to the cost of health insurance, in-lieu of coverage. Payments appear on each paycheck; federal and state taxes are withheld on each payment. Health In-Lieu payment amounts are available on the *Health and Dental Bi-Weekly Rates* sheet available in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) and on the department's intranet site: www.csj.gov.

How to Enroll

Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for proof of alternate coverage, which can be submitted within two weeks of enrollment.

2. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* and check off 'Health In-Lieu' as your choice. Return this form to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. You MUST provide evidence of acceptable alternate health coverage when you enroll. Re-enrollment is not necessary; payments will continue from one year to the next.

Enrollment Period

To participate in the Health In-Lieu plan, you must enroll within thirty (30) days of your first day of employment, or during the open enrollment period in November. You may apply for Health In-Lieu during the year only if you become eligible due to a Change in Family Status, and you must apply within 30 days of the date of that change. A Change in Family Status is defined as follows:

- Change in marital status – marriage, divorce, or legal separation
- Change in dependent status – birth, adoption, legal guardianship, or death
- Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

If you decide to enroll in the Health In-Lieu plan after your first 30 days of employment, or if you miss the 30-day time limit after a Change in Family Status, you must wait for the next open enrollment period.

Voluntary Cancellation

Employees who participate in the Health In-Lieu plan **may cancel** their participation and enroll in one of the available health insurance plans **during open enrollment only**. Cancellation will become effective with the first pay period of the following calendar year.

You may be allowed to make mid-year health plan enrollment changes (outside of Open Enrollment) only if you have a Change in Family Status (see details above under "Enrollment Period".) You must contact Employee Benefits within 30 days of such family status changes to inquire about changing your plan enrollments.

Mandatory Cancellation

If you enroll in the Health In-Lieu plan and your alternate coverage is lost prior to the next open enrollment period, you **must** notify Employee Benefits immediately. Upon receipt of documentation that your coverage has been lost (from the providing employer or group insurer) you may enroll in any one of the four City health insurance plans.

Excess In-Lieu Payments Received

If you cancel your Health In-Lieu plan and enroll in an available health insurance plan due to loss of alternate health coverage, the City's policy is to make coverage in the health plan effective the date the employee's alternate coverage is lost. YOU ARE RESPONSIBLE FOR REPAYMENT OF ANY EXCESS HEALTH IN-LIEU PAYMENTS YOU MAY HAVE RECEIVED. YOU ARE ALSO RESPONSIBLE FOR PAYING THE EMPLOYEE PORTION OF PREMIUMS NECESSARY TO BEGIN YOUR CITY HEALTH PLAN COVERAGE FOLLOWING CESSATION OF YOUR OTHER HEALTH COVERAGE.

DENTAL INSURANCE

The City offers a choice of two dental insurance plans: the Delta Dental PPO Plan of California and the DeltaCare/PMI HMO dental plan. A Dental-in-Lieu Plan is available for employees who have alternate coverage through another group dental plan. Plan information and rate sheets are available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of three City dental plans.

Cost

Your contribution and the City's contribution are subject to change each year in July in accordance with contract renewals. The percentage that you pay of the entire monthly premium is determined by your *Memorandum of Agreement (MOA).* Information on current premium rates is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The two dental insurance plans are pre-tax benefits. This means your premiums are paid before withholding taxes are taken from your paycheck. Consequently, your premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison, Evidences of Coverage, and plan brochures for each dental plan describing their respective services. To select your dental plan, please carefully read these materials. Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if you are adding a domestic partner and/or proof of alternate coverage if you are enrolling in the Health In-Lieu plan.

2. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Add Dependents* form will be required if you are adding a spouse, domestic partner, or child dependent(s).

Default Enrollment

If you do not turn in your *Health, Dental, & Vision Enrollment/Change Form* within your first 30 days of employment, you will be enrolled in the DeltaCare/PMI HMO plan (unless you complete an *Request to Waive Insurance* form available in the Employee Services Department). Your dependents will not be enrolled. You will have to wait for the annual open enrollment period in November to change to another plan or to enroll your dependents. Any change made at open enrollment will not take effect until January of the following year.

When Does Coverage Begin?

You and your eligible dependents may use your selected dental plan starting on the first day of the month following the date of your enrollment. You will be given the date on which your coverage takes effect when you enroll on-line or when Employee Benefits receives your completed enrollment form.

Coordination of Benefits

If you or your dependents are entitled to benefits under more than one dental plan (dual coverage), benefits are calculated so that payments by all plans will not be greater than the total cost of the covered services received. If dual coverage does exist, and the benefit amount exceeds the co-payment fee, then no co-payment fee will be charged to the patient.

DeltaCare/PMI will coordinate benefits only if a non-emergency service is provided through a DeltaCare/PMI dentist that you have already selected as your primary care dentist. The DeltaCare/PMI Prepaid Dental Plan makes no co-payment toward dental work done at any other location except in an emergency situation when DeltaCare/PMI may reimburse you up to $100 for covered procedures.

Be sure to tell your dentist about all dental plans under which you and your family are covered.

Dental Insurance Claims Appeal/Complaint Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the dental insurance company within sixty (60) days of the denial.

AFTER you have contacted your dental insurance company to file an appeal and utilize the plan's grievance process, you may file a complaint against your dental plan, with the California Department of Managed Health Care (DMHC). The DMHC requires that your dental plan provider advise their members of the following:

> *The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.*

When Coverage Terminates

Dental coverage for you or your dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for you and your qualified dependents.

DENTAL PLAN OPTIONS

DELTA DENTAL PPO PLAN OF CALIFORNIA
DELTA PREFERRED OPTION (PPO) PLAN
(GROUP # 2584)

Delta Dental PPO of California is an indemnity dental plan. You may go to any dentist and may change dentists as often as you wish.

Summary Benefit Information

- Currently, the annual maximum benefit for dental services per person per calendar year is $1,500 with no annual deductible (*Note: bargaining groups (unions) negotiate changes in coverage periodically on an individual basis. Consult your latest Memorandum of Agreement (MOA) to find out what your annual maximum is).*
- Delta generally pays 85% of the covered benefit for basic and routine services.
- Delta generally pays 85% for crowns, 60% for dentures and bridges.
- Delta currently pays 60% of orthodontic costs up to a lifetime maximum of $2,000 per person. All orthodontia work must be pre-approved by Delta and must be medically necessary in order to receive coverage. (*Note: As with annual maximum benefit, please consult your latest MOA to find out what your current lifetime maximum is).*
- Delta will pay 100% of the covered benefit for diagnostic and preventative services if your dentist is a Delta PPO (Delta Preferred Option) member. Contact your dentist to find out if he is a PPO member, call Delta, or use Delta's web site to find a PPO dentist in your area.
- Delta Dental does not send new enrollees a member card upon their initial enrollment; however, access to coverage is always available by providing your name, social security number and the City's Delta Dental group number (2584) to your dentist upon request.
- For more detailed coverage information, please refer to Delta Dental's *Evidence of Coverage* available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285), or on the department's intranet site: www.csj.gov.

Contact Delta Dental

Delta Dental's Customer Service Center (1-800-765-6003) can assist you with questions regarding claims, eligibility, usage, and network. You may also find personalized information by logging on to Delta Dental's website. If you have already enrolled in Delta Dental, name and social security number recognition on their website will become available within two weeks of your initial effective date of coverage. Login instructions are provided within the site.

Contact Delta by phone:	1-800-765-6003
Or visit their web site:	www.deltadentalca.org

DELTACARE/PMI OF CALIFORNIA
DENTAL HMO PLAN
(GROUP #5643)

DeltaCare/PMI is a prepaid dental health maintenance organization (DHMO) that provides direct services through its exclusive dentist network. You must select a primary care dentist from the list of DeltaCare/PMI providers when you enroll in DeltaCare/PMI.

Summary Benefit Information

- Unlimited annual benefit for dental services. No annual deductible.
- DeltaCare/PMI generally pays 100% of the covered benefit for most diagnostic and preventative services.
- General cleanings/exams are allowed twice in a calendar year at no cost. Two additional cleanings are available in the same calendar year for a $45 co-pay per cleaning.
- When there is a co-pay for crowns and bridges, enrollees pay a fixed amount for each covered dental procedure.
- The patient will be responsible for a co-payment of $1,000 for medically and non-medically necessary orthodontia. Coverage is limited to once per eligible member per lifetime.
- Teeth whitening (external bleaching – per arch) is covered at $125 per arch when accessed from your primary care dentist.
- DeltaCare/PMI will send new enrollees a member card within 10-14 days after enrollment; however, access to coverage is available by providing your social security number and the City's DeltaCare/PMI group number (5643) when you first encounter your primary care dentist.
- For more detailed access or coverage information, please refer to DeltaCare/PMI's dental plan co-payment booklet or *Evidence of Coverage* available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285), or on the department's intranet site: www.csj.gov.

Contact DeltaCare/PMI

DeltaCare/PMI's Customer Service Center (1-800-422-4234) can assist you with questions regarding claims, eligibility, usage, and network. You may also find personalized information by logging on to DeltaCare/PMI's website. If you have already enrolled in DeltaCare/PMI, name, date of birth, and social security number recognition on their website will become available within two weeks of your initial effective date of coverage. Log-in instructions are provided within the site.

Contact DeltaCare/PMI by phone:	1-800-422-4234
Or visit their web site:	www.deltadentalca.org/pmi

DENTAL IN-LIEU PLAN

The City of San Jose's Dental In-Lieu plan provides eligible employees a cash incentive to forego coverage under one of the City's available dental plans when employees can furnish proof of alternate coverage.

Eligibility

Full-time and Reduced Work Week (35+ hours per week) employees who have alternate dental insurance coverage through another group dental plan may participate in the Dental In-Lieu plan, or may choose coverage under one of the two dental plans described above.

In-Lieu Payments

Participants in the Dental In-Lieu plan receive a cash payment of 50% of the City's contribution to the cost of dental insurance, in-lieu of coverage. Payments appear on each paycheck; federal and state taxes are withheld on each payment. Dental In-Lieu payment amounts are available on the *Health and Dental Bi-Weekly Rates* sheet available in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) and on the department's intranet site: www.csj.gov.

How to Enroll

Employees have two options for enrollment:

3. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for proof of alternate coverage, which can be submitted within two weeks of enrollment.

4. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* and check off 'Dental In-Lieu' as your choice. Return this form to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. You MUST provide evidence of acceptable alternate dental coverage when you enroll. Re-enrollment is not necessary; payments will continue from one year to the next.

Enrollment Period

To participate in the Dental In-Lieu plan, you must enroll within thirty (30) days of your first day of employment, or during the open enrollment period in November. You may apply for Dental In-Lieu during the year only if you become eligible due to a Change in Family Status, and you must apply within 30 days of the date of that change. A change in Family Status is defined as follows:

- Change in marital status – marriage, divorce, or legal separation
- Change in dependent status – birth, adoption, legal guardianship, or death
- Change in work status (either employee or employee's spouse) – termination of employment, commencement of employment, or change between part-time and full-time employment

If you decide to enroll in the Dental In-Lieu plan after your first 30 days of employment, or if you miss the 30-day time limit after a Change in Family Status, you must wait for the next open enrollment period.

Voluntary Cancellation

Employees who participate in the Dental In-Lieu Plan **may cancel** their participation and enroll in one of the available dental insurance plans **during open enrollment only**. Cancellation will become effective with the first pay period of the following calendar year.

You may be allowed to make mid plan-year enrollment changes (outside of Open Enrollment) only if you have a Change in Family Status (see details above under "Enrollment Period".) You must contact Employee Benefits within 30 days of such family status changes to inquire about changing your plan enrollments.

Mandatory Cancellation

If you enroll in the Dental In-Lieu plan and your alternative coverage is lost prior to the next open enrollment period, you **must** notify Employee Benefits immediately. Upon receipt of documentation that your coverage has been lost (from the providing employer or group insurer) you may enroll in either of the two City dental insurance plans.

Excess In-Lieu Payments Received

If you cancel your Dental In-Lieu plan and enroll in an available dental insurance plan due to loss of alternate dental coverage, the City's policy is to make coverage in the dental plan effective the date the employee's alternative coverage is lost. YOU ARE RESPONSIBLE FOR REPAYMENT OF ANY EXCESS DENTAL IN-LIEU PAYMENTS YOU MAY HAVE RECEIVED. YOU ARE ALSO RESPONSIBLE FOR PAYING THE EMPLOYEE PORTION OF PREMIUMS NECESSARY TO BEGIN YOUR CITY DENTAL PLAN COVERAGE FOLLOWING CESSATION OF YOUR ALTERNATE DENTAL COVERAGE.

VISION CARE INSURANCE

The City offers you a choice of two vision care plans: Cole Managed Vision and Vision Service Plan (VSP). A brief summary of each plan is presented here. Plan information and rate sheets are available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or on the department's intranet site: www.csj.gov.

Eligibility

All full-time and part-time benefited employees may enroll themselves and their eligible dependents in one of two City vision plans.

Cost

Your contribution and the City's contribution are subject to change each year in July in accordance with contract renewals. Your Memorandum of Agreement (MOA) determines the percentage that you pay of the entire monthly premium. Information on current premium rates is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285). Please contact the Office of Employee Relations (City Hall Wing, 2nd Floor, 535-8150) for more information regarding the City's cost sharing arrangement.

Pre-Tax Premiums

The two vision plans are pre-tax benefits. This means your premiums are paid before withholding taxes are taken from your paycheck. Consequently, your premiums are not subject to state or federal taxes (please refer to the *Affidavit of Domestic Partnership* form for more information regarding exceptions to this rule).

How to Enroll

Employee Benefits provides a detailed plan comparison and plan brochures for each vision plan describing their respective services. To select your vision plan, please carefully read these materials. Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required except for the *Affidavit of Domestic Partnership* if you are adding a domestic partner and/or proof of alternate coverage if you are enrolling in the Health In-Lieu plan.

2. Complete and return the City's *Health, Dental, & Vision Enrollment/Change Form* to Employee Benefits within the first thirty (30) days of your date of hire/benefits eligibility. A marriage certificate, *Affidavit of Domestic Partnership*, or *Request to Add Dependents* form will be required if you are adding a spouse, domestic partner, or child dependent(s).

When Does Vision Care Coverage Begin?

You and your eligible dependents may use your selected vision plan starting on the first day of the month following the date of your enrollment. You will be given the date on which your coverage takes effect when you enroll on-line or when Employee Benefits receives your completed enrollment form.

Mandatory 24-Month Vision Plan Commitment

IN ORDER TO ENROLL IN EITHER VISION PLAN, YOU MUST BE WILLING TO REMAIN ENROLLED FOR 24 MONTHS. THIS MANDATORY 24-MONTH COMMITMENT IS IN PLACE TO ENSURE THAT VISION PLAN RATES REMAIN STABLE. EMPLOYEES MAY ONLY DROP COVERAGE OR SWITCH PLANS DURING OPEN ENROLLMENT AFTER THE 24-MONTH REQUIREMENT IS MET.

Vision Insurance Claims Complaint/Appeal Procedures

The insurer is responsible for making the final determinations for benefits described in this handbook. To appeal the denial of any insurance claim, write to the vision insurance company within sixty (60) days of the denial.

AFTER you have contacted your vision insurance company to file an appeal and utilize the plan's grievance process, you may file a complaint against your vision plan, with the California Department of Managed Health Care (DMHC). The DMHC requires that your vision plan provider advise their members of the following:

> *The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number (1-800-400-0815) to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (1-800-735-2929 (TTY) or 1-888-877-5378 (TTY)) to contact the department. The department's Internet website (http://www.dmhc.ca.gov) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at (1-800-877-7195) and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.*

When Coverage Terminates

Vision coverage for you or your dependents will end on the last day of the month in which benefits eligibility or enrollment terminates. Coverage will also terminate if you choose to drop your vision plan enrollment (after completing the 24-month commitment).

Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, MRA or EAP benefits continuation for you and your qualified dependents.

VISION PLAN OPTIONS

COLE MANAGED VISION
(GROUP# 30218)

Cole Managed Vision is the largest optical retailer in the United States, operating primarily under the "Pearle Vision," "Sears Optical," "Target Optical," and "JC Penny Optical" names.

Summary Benefit Information

- **Office Visit:** $10 Co-pay
- **Spectacle Exams**: Paid in full every 12 months
  (Contact lens exams may require additional fees)
- **Spectacle Lenses**: Paid in full every 12 months
  (Options other than 'standard' are available at additional cost)
- **Covered Frames**: Paid up to $115 retail allowance every 12 months
  (Alternative frames may involve additional cost)
- **Contact Lenses**: Paid up to $250 every 12 months if medically required
  (Covered up to $100 retail if elected in lieu of spectacles)

Accessing In-Network Services

Contact the facility at which you intend to receive services. Provide the facility with your name, social security number, and the City of San Jose's group number (30218). The facility will contact Cole Managed Vision to verify eligibility and setup your appointment.

Accessing Out-of-Network Services

Coverage for services is reduced for services accessed out of the Cole Managed Vision network of providers and facilities. Employees should contact Cole Managed Vision prior to accessing out-of-network services whenever possible to verify limitations or exclusions in coverage. You will be responsible for paying the provider in full at the time services are rendered. For reimbursements, simply call Cole's Customer Service Center at 1-800-334-7591 to verify eligibility and receive a claim form. Mail the completed claim form with a copy of your bill to:

Cole Vision Services, Inc.
1925 Enterprise Parkway
Twinsburg, OH 44087
Attn: Vision Care Department

Contact Cole Managed Vision

Cole Managed Vision's Customer Service Center can assist you with questions regarding claims, eligibility, usage, and network. Though Cole Managed Vision does not provide member-specific information on-line, you can find provider lists on their Internet website.

Contact Cole by phone:	1-800-334-7591
Or visit their web site:	www.colemanagedvision.com

VISION SERVICE PLAN (VSP)
(GROUP#12112926)

Vision Service Plan (VSP) is the nation's leading vision plan. Members receive care from a national network of more than 18,000 independent optometrists and ophthalmologists.

Summary Benefit Information

- **Office Visit:** $10 Co-pay
- **Spectacle Exams**: Paid in full every 12 months (Contact lens exams may require additional fees)
- **Spectacle Lenses**: Paid in full every 12 months (Options other than 'standard' are available at additional cost)
- **Covered Frames**: Paid up to $115 retail allowance every 24 months (Alternative frames may involve additional cost)
- **Contact Lenses**: Paid in full every 12 months if medically required (Covered up to $105 retail if elected in lieu of spectacles)

Accessing In-Network Services

Contact a participating VSP vision provider's office. Give them your full name, date of birth, Social Security Number, and notify them that you have coverage under the City of San Jose's VSP plan (Group#: 12112926). The provider's office will then verify your eligibility with VSP and schedule your appointment.

Accessing Out-of-Network Services

Coverage for services is reduced for services accessed out of the Vision Service Plan network of providers. Employees should contact VSP prior to accessing out-of-network services whenever possible to verify limitations or exclusions in coverage. You are responsible for paying the provider in full at the time you access services. At that time, request an itemized receipt of products and services rendered. Then send this information along with a letter requesting reimbursement to:

Vision Service Plan
PO Box 997100
Sacramento, CA 95899-7100

Be sure to include the Employee's social security number, name, the City's group number, the patient's name, relationship to employee, date of birth, phone number, and address.

VSP Insurance Claims Complaint/Appeal Procedures

If a subscriber/enrollee (hereafter "enrollee") has a complaint/grievance (hereafter "grievance") regarding VSP service or claim payment, the enrollee may communicate the grievance to VSP by using a form which is available by calling VSP's Customer Service Department's toll free number (1-800-877-7195) Monday through Friday, 6:00 a.m. to 7:00 p.m. (PST). Grievances may be filed in writing with VSP at 333 Quality Drive, Rancho Cordova, California 95670.

Upon receipt of a verbal or written grievance, VSP will respond in writing to the enrollee acknowledging receipt and/or disposition of the grievance within five (5) business days. VSP is generally responsible for resolving grievances within thirty (30) days from the date of receipt. VSP will keep all grievances and the responses thereto on file for seven years.

Contact Vision Service Plan

VSP's Customer Service Center can assist you with questions regarding claims, eligibility, usage, and network. Personalized information regarding these areas is also available on VSP's website. Your social security number and last name will be requested for access.

Contact VSP by phone:	1-800-877-7195
Or visit their web site:	www.vsp.com

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Counseling services are available for marital, family, interpersonal, emotional and drug abuse issues. In addition, a number of life management services are available to help you with child & elder care, legal, financial, credit, IRS, and retirement issues.

Eligibility

All full-time and part-time benefited employees and their eligible dependents may access EAP counseling and life management services.

Cost

The eligible employee pays nothing to participate. The City of San Jose contributes 100% of your monthly premium.

How to Enroll

You are automatically enrolled if you are a full-time or part-time benefited employee.

When Does EAP Coverage Begin?

You and your eligible dependents may use the counseling or life management services on the first of the month following your date of hire or benefits eligibility.

Counseling Benefits

The first five (5) visits* per incident per year are free. If additional appointments are necessary, you will have to pay for them. However, as a City employee, you will pay a reduced rate for additional counseling services.

If an incident is exceptionally serious, your counselor may refer you or your dependent to a psychologist or to another agency in a special field of expertise.

If referred to EAP by your supervisor for a work-related problem, you do not have to pay for additional appointments after your first 5 appointments. Visiting an EAP counselor at the recommendation of your supervisor is usually voluntary, but in some cases it may be mandatory. Refer to your MOA for specific information.

* The limit of five (5) visits per incident does not apply to sworn police and fire employees, safety dispatchers, and their respective dependents.

Work and Life Services

Unlimited telephone consultations are available to employees and their eligible dependents for life management services. Examples of work and life consultation areas include Pre-Retirement Planning, Financial Planning, Child & Elder Care Referral, Taxpayer Consultations, Legal Guidance (for questions regarding wills & contracts or questions related to family, real estate, personal injury, criminal and consumer law), and Concierge Services.

Telephone consultation sessions are usually limited from 30 to 60 minutes for each call; however, eligible participants are entitled to an unlimited number of free consultations throughout the year.

Accessing EAP Services

Contact MHN directly to schedule counseling or work and life services by calling the following toll-free number: **1-800-227-1060** ***(TDD Line: 1-800-327-0801***).

When you speak with the MHN intake staff, tell them you are covered under the City of San Jose's EAP program. Also, provide your name and the City employee's name under whom you are covered. MHN will require this information to verify your eligibility for services**.**

Confidentiality Assurance

Visits to a counselor are completely confidential unless the participant undergoing counseling authorizes the release of information by signing a release form. If you encounter service issues with an MHN provider or facility and you are concerned about maintaining your privacy within the City, please refer to the EAP Service Disputes and Complaints section below.

EAP Service Complaint/Appeals Procedures

If you have a complaint or dispute about MHN's services or practitioners, just call the toll-free number: 1-800-887-1060. You may also submit a complaint in writing to: *MHN, Quality Management Department, 1600 Los Gamos Drive, Suite 300, San Rafael, CA 94903.*

Complaints are investigated and resolved by MHN Quality Management staff. Complaints are acknowledged within 5 working days and, with specific exceptions, are resolved within 30 days of MHN's receipt of the complaint. If you are dissatisfied with the outcome of your complaint, you may appeal in writing to: *MHN, Appeal Unit, 5100 Goldleaf Circle, Suite 300, Los Angeles, CA 90056.*

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC at 1-888-HMO-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers: 1-800-735-2929 (TTY) or 1-888-877-5378 (TTY) to contact the DMHC. The DMHC's website (www.dmhc.ca.gov) also has complaint forms and instructions online.

When Coverage Terminates

Your EAP coverage will end on the last day of the month in which your employment or benefits eligibility terminates. Your dependents' coverage will end on the last day of the month in which either you or your dependents are no longer eligible.

Continuation of coverage may be available. Refer to the *COBRA Coverage* section of this document for more information about Health, Dental, Vision, EAP, or MRA benefits continuation for you and your qualified dependents.

Additional Information

For more information on EAP services for you and your family, information is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285), or on the department's Intranet site: www.csj.gov.

COBRA COVERAGE

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provides that the same health, dental, vision, MRA, and EAP benefits be made available for employees, former employees, and dependents when they lose coverage after a qualifying event.

Employee Rights

COBRA allows benefited employees (and any covered dependents) to continue health, dental, vision, MRA, or EAP benefits at their own expense for thirty-six (36) months after the month in which one of the following qualifying events occurs:

- Termination of your employment (other than for gross misconduct).
- Loss of benefited status whether by reduction in your work hours or change in your job classification.

Dependent Rights

Employees' covered dependents may continue their coverage for thirty-six (36) months after one of these qualifying events:

- An employee's death.
- A divorce or legal separation from an eligible employee.
- A dependent child's loss of dependent status (either for a dependent child who is not a full-time student between age 19 and age 24, or for a dependent child who turns 24).

Definition of 'Eligible' or 'Qualified' Dependents

For purposes of COBRA, a qualified dependent is defined as any individual who, on the day before the qualifying event, was a covered spouse, domestic partner or a covered dependent child of an employee; or who was born to or adopted by the employee during the COBRA continuation period.

Eligibility Notifications

When an employment or family status change occurs in the City's HR/Payroll system that results in your or your family members' loss of benefits eligibility (such as separation from City service, loss of benefited status, divorce, or a dependent child's loss of FT student status), the City will notify the qualified beneficiaries of their COBRA rights within 14 days of the qualifying event or upon receiving notification of the same. Consequently, if you or your dependent ceases to become eligible for the City's Health, Dental, Vision, MRA, or EAP benefits, you must inform Employee Benefits (535-1285) immediately.

Election Requirements

If you or your dependents wish to continue coverage under COBRA, you or they must notify the City within sixty (60) days after receiving the City's notification of the qualified beneficiaries' COBRA rights, or within sixty (60) days after losing coverage after a qualifying event, whichever is later.

You or your dependents will then have forty-five (45) days to make the initial premium payment along with any subsequent premiums due for months following the qualifying event. The cost to continue coverage under COBRA will be the total cost of the premium plus a minimal administrative fee which cannot legally exceed 2% above the premium cost for active employees.

Please contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for more information regarding administration and premium remittance.

When Does COBRA Coverage End?

Continued coverage under COBRA will terminate at the end of the month in which any of the following occur:

- The allowable number of months of continued coverage expires.
- Premiums are not paid as required.
- The person covered becomes eligible for health benefits under another health plan, or becomes eligible for Medicare benefits.

Once COBRA Coverage Terminates, It Cannot Be Reinstated.

Health Insurance Portability and Accountability Act (HIPAA)

The City of San Jose does not exclude anyone with pre-existing medical conditions from health, dental, vision, or EAP coverage. However, if you leave City employment for another job, your new employer may have such exclusions. A pre-existing medical condition exclusion generally may not be imposed for more than 12 months, and this limitation period is reduced if you had prior health coverage. You are entitled to a *Certificate of Coverage* that provides evidence of your prior health coverage. Your City health insurer will provide this *Certificate of Coverage* when your City health coverage ends. Contact Employee Benefits if your new employer or individual health insurer asks for a *Certificate of Coverage* and you did not receive one from your former City insurer.

Additional Information

If you have any questions about COBRA continuation or would like to take advantage of your COBRA opportunity, please contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

MEDICAL REIMBURSEMENT ACCOUNT (MRA)

The City offers its employees a Medical Reimbursement Account (MRA) in accordance with IRS Sections 125/129. The current Plan Administrator (account manager) is AFLAC Flex-One. Normally you pay for out-of-pocket healthcare expenses with money that has already been taxed. However, using the MRA program, your out-of-pocket expenses can be reimbursed from a trust account funded with pre-tax deductions from your paycheck. This reduces your taxable income so you will pay less in taxes and have more money to spend and save.

Eligibility

All Full and Part-time benefited employees are eligible to participate in the Medical Reimbursement Account (MRA).

Cost

There are no administrative fees for participating in one or both of the City's Flexible Spending Accounts: MRA or DCAP.

How to Enroll

Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

2. Contact the City's AFLAC representative within 30 days of your date of hire or benefits eligibility. Otherwise, you will be required to enroll in the MRA program during Open Enrollment in November. Contact information is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

Reimbursable Expenses

The following are examples of expenses that qualify as 'reimbursable' under the MRA plan:

- Insurance copayments
- Unreimbursed medical/dental expenses
- Acupuncture, Chiropractic, Homeopathic Therapy, etc.
- Contact lens solution
- Laser eye surgery

Please consult the MRA plan administrator for a complete and current list of eligible expenses.

"Use It or Lose It" Rule

If you decide to enroll, be sure to designate an annual amount that will cover only expenses that you know you will have during the plan year. If you do not spend all the money that you designated for the plan year, the remaining account balance is lost. It cannot be returned to you according to the IRS' "use it or lose it" rule.

Plan Year Grace Period

Due to a change in legislation on May 18, 2005, the IRS allows MRA participants to continue to incur expenses for 2 ½ months after the end of the plan year. For example, if you were enrolled in the MRA for the 2006 plan year, you could continue to incur expenses for reimbursement until March 15, 2007. Participants would be reimbursed from any balance remaining in the account from the 2006 plan year election.

How the Plan Works

1. With the assistance of the Plan Administrator or your tax advisor, you will be asked to estimate your annual out-of-pocket healthcare expenses.
2. That amount is divided by 24 payperiods and deducted from your paycheck semi-monthly before taxes are applied to your gross earnings. This reduces the amount of money on which you have to pay taxes.
3. After the money is deducted, it is banked for you in a tax-free reimbursement account.
4. Upon your request, the Plan Administrator or Employee Benefits will provide you with a *Request for Reimbursement Form* to use for your reimbursement requests. You may request reimbursement biweekly, monthly, or once a year; the choice is yours.
5. Requests for reimbursement will be processed within three (3) days after the Administrator receives a complete, accurate form. A check or direct deposit will be issued for the amount you requested from your Reimbursement Account soon thereafter.
6. Periodically throughout the year, the Plan Administrator will provide you with a statement of your account. Read these statements carefully so you understand the amount remaining in your reimbursement account.

Tax Advantage Illustration

	Without MRA/DCAP	With MRA/DCAP
Annual Income:	$51,000	$51,000
Designated Annual Amount:	- $ 0	- $ 1,000
Taxable Income:	$51,000	$50,000
Taxes Taken Out at 25%*:	- $12,750	- $12,500
Take-home Pay (*After Taxes*):	$38,250	$37,500
Out-of-Pocket Expenses:	- $1,000	- $1,000
Reimbursements (*Using Pre-Tax Deductions*)	$0	$1,000
Net Income:	$37,250	$37,500
Annual Tax Savings*:	**$250**	

** This example is for illustration purposes only. In no way should this example be used to calculate your actual tax savings. Please consult a qualified tax advisor for more information about how these pre-tax programs will benefit you, specifically.*

When Does MRA Participation Terminate?

Your MRA account will close at the end of each calendar year. Your eligibility to participate prospectively in this pre-tax program will end either on the last day of the calendar year or on the last day you are employed or the last day on which you were eligible for the MRA benefit. If you participated in a plan year and at some point separate from City service or cease to be eligible for the MRA benefit, you may request reimbursements from the account retroactively for the period in which you were an active participant.

Additional Information

If you are looking for more detailed summary information, AFLAC's *Flexible Spending Account Participant Handbook* is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

For answers to more specific questions about the City's Medical Reimbursement Account program please call AFLAC-Flex One: 1-877-353-9487.

DEPENDENT CARE ASSISTANCE PROGRAM (DCAP)

The City offers its employees a Dependent Care Assistance Program (DCAP) in accordance with IRS Sections 125/129. The current Plan Administrator (account manager) is AFLAC Flex-One. Normally you pay for dependent care with money that has already been taxed. However, using the DCAP program, your dependent care expenses can be paid from a trust account funded with pre-tax deductions from your paycheck. This reduces your taxable income so you will pay less in taxes and have more money to spend and save.

Eligibility

- You may participate if you are a full-time or part-time benefited employee.
- You must be at work while your child or other dependent is receiving care. If you are married, your spouse must also be employed, or be a full-time student, or be disabled.
- Eligible children must be 12 or under. Other dependents (such as children age 13 or over, parents, or a spouse) are eligible only if they are disabled or cannot care for themselves because of physical or mental disability.
- The child, or other dependent, receiving care must live in your home, and must be claimed as a dependent on your federal income tax return.
- You must pay a "qualified person" to care for your eligible dependent at your home, at a licensed day care center, or at another location. Any overnight camps or any schools for first grade or above are **not** qualified. A "qualified person" does **not** include any of your children under 19, or any other person whom you claim as a dependent.
- You must show the name, address, and taxpayer identification number of any persons or dependent care centers that you pay to provide dependent care on your federal income tax return.

Cost

There are no administrative fees for participating in one or both of the City's Flexible Spending Accounts: MRA or DCAP.

How to Enroll

Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

2. Contact the City's AFLAC representative within 30 days of your date of hire or benefits eligibility. Otherwise, you will be required to enroll in the DCAP program during Open Enrollment in November. Contact information is available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

Qualified Dependent Care

The following types of dependent care arrangements qualify for the DCAP plan:

- A dependent day care center where care is provided for more than six (6) individuals.

The facility must comply with applicable state and local laws.

- An educational institution for pre-school children. For older children, only expenses for non-school care are eligible.
- An individual who provides care inside or outside your home. This person may not be your child under 19, or anyone you claim as a dependent for Federal tax purposes.

"Use It or Lose It" Rule

If you decide to enroll, be sure to designate an annual amount that will cover only expenses that you know you will have during the plan year. If you do not spend all the money that you designated for the plan year, the remaining account balance is lost. It cannot be returned to you according to the IRS' "use it or lose it" rule.

How the Plan Works

1. With the assistance of the Plan Administrator or your tax advisor, you will be asked to estimate your annual out-of-pocket dependent care expenses.
2. That amount is divided by 24 payperiods and deducted from your paycheck semi-monthly before taxes are applied to your gross earnings. This reduces the amount of money on which you have to pay taxes.
3. After the money is deducted, it is banked for you in a tax-free reimbursement account.
4. Upon your request, the Plan Administrator or Employee Benefits will provide you with a *Request for Reimbursement Form* to use for your reimbursement requests. You may only request reimbursement for expenses as you contribute to your DCAP account. **You may not request reimbursement in excess of your year-to-date deposits**.
5. Requests for reimbursement will be processed within three (3) days after the Administrator receives a complete, accurate form. A check or direct deposit will be issued for the amount you requested from your Reimbursement Account soon thereafter.
6. Periodically throughout the year, the Plan Administrator will provide you with a statement of your account. Read these statements carefully so you understand the amount remaining in your reimbursement account.

Tax Advantage Illustration

	Without MRA/DCAP	**With MRA/DCAP**
Annual Income:	$51,000	$51,000
Designated Annual Amount:	- $ 0	- $ 1,000
Taxable Income:	$51,000	$50,000
Taxes Taken Out at 25%*:	- $12,750	- $12,500
Take-home Pay (*After Taxes*):	$38,250	$37,500
Out-of-Pocket Expenses:	- $1,000	- $1,000
Reimbursements (*Using Pre-Tax Deductions*)	$0	$1,000
Net Income:	$37,250	$37,500
Annual Tax Savings*:	**$250**	

** This example is for illustration purposes only. In no way should this example be used to calculate your actual tax savings. Please consult a qualified tax advisor for more information about how these pre-tax programs will benefit you, specifically.*

When Does DCAP Participation Terminate?

Your DCAP account will close at the end of each calendar year. Your eligibility to participate prospectively in this pre-tax program will end either on the last day of the calendar year or on the last day you are employed or the last day on which you were eligible for the DCAP benefit. If you participated in a plan year and at some point separate from City service or cease to be eligible for the DCAP benefit, you may request reimbursements from the account retroactively for the period in which you were an active participant.

Additional Information

If you are looking for more detailed summary information, AFLAC's *Flexible Spending Account Participant Handbooks* are available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

For answers to more specific questions about the City's Dependent Care Assistance Program please call AFLAC-Flex One: 1-877-353-9487.

LIFE INSURANCE

The City provides coverage through a group policy with Standard Insurance Company.

Eligibility

All full-time benefited employees are eligible to participate in the City's group life insurance policy (part-time benefited and temporary employees are not eligible for life insurance). Employees are eligible for Basic, Supplemental, and Dependent coverage options.

Cost

For details on Supplemental and Dependent coverage premiums please contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) or refer to the department's intranet site: www.csj.gov. Premiums are paid through regular after-tax payroll deductions and are subject to change each July.

Management employees should note that the Basic coverage premiums paid by the City for Basic coverage exceeding $50,000 are subject to federal taxation as additional earnings in accordance with IRS rules (only the premium is taxed, not the coverage amount).

How to Enroll

Employees have two options for enrollment:

1. Employees can enroll and select beneficiaries on-line through the City's Intranet site, www.csj.gov/eway, for Basic Life, Dependent Life and Supplemental life insurance, (for one (1x) times your annual salary, up to $100,000), during the first 30 days after hire or benefits eligibility. No paper forms are required.

2. Employees can enroll using paper forms. Please note that the ***Medical History Statement*** is required for supplemental life amounts of two, three, or four times your annual salary.
    a. Basic and Dependent Coverage (1st 30 Days) – Complete the enrollment card at the back of your life insurance brochure indicating the coverage you would like to elect. Basic and Dependent coverage will be guaranteed if you enroll within the first 30 days of employment or benefits eligibility, so no *Medical History Statement* will be required for these options.

    b. Supplemental Coverage: additional one (1x) times your annual salary (1st 30 Days) – Supplemental life insurance coverage of one (1x) times your annual salary, up to $100,000, will be guaranteed if you enroll within the first 30 days of employment or benefits eligibility, so no *Medical History Statement* will be required for this option.

    c. Supplemental Coverage: up to four (4x) times your annual salary (1st 30 Days) – If you wish to apply for Supplemental life insurance coverage over the guaranteed one (1x) times your annual salary and/or the $100,000 cap, you must also submit a completed *Medical History Statement* form. Your application for coverage will be subject to The Standard Insurance Company's underwriting review process. Notification of denial/approval will be sent once a determination has been made by The Standard Insurance. Supplemental coverage will become effective on the day of approval. Deductions will begin shortly thereafter.

d. Basic, Supplemental, & Dependent Coverage (After the 1st 30 Days) – If you wish to enroll in any of the coverage options or wish to increase your coverage after your first thirty (30) days of employment, you must complete a *Medical History Statement* for Basic, Supplemental, and Dependent coverage. Approval will be subject to The Standard Insurance Company's medical underwriting review. If you are approved, coverage will begin the on the date of your approval.

e. Return the enrollment card to Employee Benefits in the Employee Services (City Hall Wing, 2nd Floor, 535-1285). At that time, Employee Benefits will notify you when your guaranteed coverage (if applicable) takes effect.

Basic Life Insurance (City Paid)

- Non-management: All full-time non-management employees are insured for $10,000 (IAFF and POA), or $20,000 (all others), as shown in your MOA.
- Management: All management employees are insured for twice their annual salary, up to a maximum of $500,000.

Supplemental Life Insurance (Employee Paid)

- Non-management: Non-management employees, if eligible, may purchase additional life insurance worth up to four (4x) times their annual salary, up to a maximum of $500,000. Eligibility is based upon medical underwriting approval as determined by The Standard Insurance Company. You pay premiums for this insurance through regular payroll deductions.
- Management: Management employees may purchase additional life insurance worth up to two (2x) times their annual salary, up to a maximum of $500,000. Eligibility is based upon medical underwriting approval as determined by The Standard Insurance Company. You pay premiums for this insurance through regular payroll deductions.

Dependent Life Insurance Coverage (Employee Paid)

You may purchase coverage, in increments of $2,000 to a maximum of $10,000, for your spouse or domestic partner and your children. Your spouse or domestic partner and each child will have the same amount of coverage.

Life Insurance Retirement Provisions

Retired City employees have three options for life insurance. *In all cases, the employee must apply within 31 days of retirement.*

Option 1. Retired City employee may purchase a lesser amount of life insurance through the City's group policy. The value of your coverage declines in steps during your retirement:

- Non-Management: Your life insurance coverage drops to $5,000 upon retirement. At age 65, it drops to $2,500.
- Management: Your life insurance coverage drops to $20,000 upon retirement. At age 65, it drops to $10,000; and at age 70, it drops to $5,000.
- Dependents Life: You may choose the Dependents Life option of $1,000 coverage (may not exceed 50% of employee's amount).

Option 2. Employee may port Life Insurance up to the lesser of (a) the amount of Basic Life plus Additional Life in force on the retiree's last day of work and (b) $300,000. The employee may also port Spouse and Child's coverage (maximum is the amount in effect on the employee's last day of work). To be eligible for this option, the Employee must be:

- Under age 70
- Must have had insurance for at least 12 months
- Must be able to work in one occupation
- If porting dependent's coverage, must port own coverage

Option 3. Employee may convert Life insurance for employee and dependents (amount as of the employee's last day of work) to an individual policy.

Accidental Death and Dismemberment (AD&D) Coverage

As part of the City's life insurance group policy with The Standard Insurance Company, you are automatically enrolled with AD&D insurance at no additional cost to you if you enrolled in the City's Basic or Supplemental life insurance coverage.

If you lose your life in an accident (or lose your life within 365 days due to injuries from that accident) your beneficiary will be paid an added amount equal to the face value of your life insurance (basic plus supplemental) in addition to your life insurance benefit.

You will be paid one-half (1/2) the face value of your life insurance (basic plus supplemental) if you suffer the loss of one hand, one foot, or the sight of one eye. You will be paid the face value of your life insurance (basic plus supplemental) if you suffer the loss of two or more of the following: hand, foot, or eyesight.

Beneficiary Designations

Review your life insurance beneficiaries after any major life event (birth, death, marriage, divorce, etc.) to ensure that the appropriate individuals will receive the life insurance benefits. Contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) to change beneficiaries. *Beneficiary Designation* forms are available on-line at the department's Intranet site: www.csj.gov.

When Coverage Terminates

If you leave City employment, you may port your current Life and AD&D insurance coverage. If you leave City employment or your full-time status ends, you may convert your life insurance coverage to an individual whole life insurance policy. You **must apply to port or convert your life insurance within thirty-one (31) days** of your last day of employment with the City. After thirty-one (31) days, you are no longer eligible for this benefit.

LONG TERM DISABILITY (LTD) INSURANCE

City employees are not covered by State Disability Insurance (SDI). Consequently, the City offers an optional, employee-paid Long Term Disability (LTD) Insurance program. Long Term Disability is an insurance policy that pays you up to 66 2/3% of your salary if you become totally disabled on or off the job by an illness, injury, or pregnancy. The City program is offered through The Standard Insurance Company.

Eligibility

All full-time and part-time benefited employees are eligible to participate in this program (temporary employees are not eligible for LTD). Coverage begins on the latter of your date of eligibility or your date of enrollment.

Cost

The current premium cost for Long Term Disability is 1.34% of your gross bi-weekly earnings. Premium payments are taken through regular payroll deductions on a bi-weekly basis. These deductions are taken after-tax to ensure that disability payments are not taxable when received.

How to Enroll

Employees have three options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. On-line enrollment is available during the first 30 days after hire or benefits eligibility. No paper forms required.
2. Complete and return the form provided with your LTD brochure to Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) within 30 days of your date of hire. Coverage takes effect on the later of your eligibility date, or your date enrolled, provided you are actively at work. (See *Certificate of Insurance*). Coverage is guaranteed if you apply within your first 30 days of hire or benefits eligibility.
3. If you wish to enroll after your first 30 days of employment, you may still apply; however, approval will be subject to your completion of a *Medical History Statement* and The Standard Insurance Company's underwriting review. If you are approved, coverage will take effect on the date of approval, provided you are actively at work.

Detailed Terms and Conditions

The description of benefits in this handbook is for summary purposes only. All terms, conditions, and limitations for this policy are listed in full in the Long Term Disability *Certificate of Insurance* available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

Claim Applications

In order to receive Long Term Disability benefits, you must submit an LTD claim application within 90 days of the date you become totally disabled. Contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for an application packet. The packet includes application instructions, forms, and a *Certificate of Insurance*.

How LTD Insurance Works

Once you are approved for an LTD claim, benefits will be payable beginning on the 31st day of continuous total disability. You will be eligible to receive a monthly benefit of up to 66 2/3% of your monthly wage or salary.
For example, if you earned $3,000 per month immediately prior to your disability, this benefit ensures that you will receive $2,000 per month once your claim is approved.

Please note that while benefits are payable, any deductible income paid, such as sick leave, is subtracted from your maximum monthly disability benefit.

Deductible Sources of Income

Deductible benefits include sick leave and most disability and retirement income from other sources. These include employer programs (e.g., pensions, as well as paid sick leave), government programs (e.g., state disability, Social Security, or Workers' Compensation), and other group insurance. Other leave payments, including vacation and compensatory time, are **not** deducted from Long Term Disability insurance payments. You'll receive a minimum LTD payment of $100 per month even if deductible benefits are more than 66 2/3% of your salary.

Definition of Total Disability

During the Elimination Period (the first 30 days of your continuous, total disability) and for the next twenty-four (24) months, total disability means the complete inability to engage in your regular occupation with the City.

After that, total disability means the complete inability to engage in **any** employment or occupation for which you are reasonably qualified, or for which you become qualified through education, training, or experience.

LTD and Family Medical Leave

Up to the first 12 weeks of your absence due to disability may run concurrent with Family Medical Leave (FMLA) or California Family Rights Act CFRA.

When Payable Benefits Terminate

After a determination is made that you are able to engage in any employment or occupation, your Long Term Disability benefit payments will cease. Payments will also cease once you reach the end of the maximum benefit period, or once you reach the program's age limit.

LTD Claims Status

If you have questions about a claim that you have filed, contact The Standard Insurance Company at (800) 648-1356, or (503) 321-7000.

When Coverage Terminates

Coverage will terminate when you leave City employment, cease to be eligible, or fail to remit premium. There is no conversion provision associated with this policy.

PERSONAL ACCIDENT INSURANCE

Personal Accident Insurance is available through the City's group policy with the Life Insurance Company of North America. This plan offers full 24-hour-a-day bodily injury protection against accidents anywhere in the world, on or off the job, on business, on vacation, and at home. Illnesses are not covered.

Eligibility

All full-time and permanent benefited part-time employees are eligible for this insurance. You may insure yourself, using the Employee Only plan, or you may insure you and your family members under the Family Plan if:

- Your spouse (or domestic partner) is under age 70.
- Your dependent children (including step, foster, legally adopted children, and children of your domestic partner) are unmarried and less than 19 years old.
- Your dependent children (including step, foster, or legally adopted children) are unmarried, under age 24, and qualify as full-time students.

No person may be covered more than once under this plan. If you are covered as an employee, you cannot be covered as a spouse, domestic partner, or dependent child of another employee. Dependents are covered at specified percentages of employee's coverage.

Please refer to the Personal Accident Insurance *Certificate of Insurance* available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for more detail regarding coverage provisions and exclusions.

Cost

Current cost and benefit information can be found in the Personal Accident Insurance brochure available from Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285).

How to Enroll

Employees have two options for enrollment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. On-line enrollment is available at any time. No paper forms are required.

2. Complete the enrollment form available in the Personal Accident Insurance brochure by selecting the amount of coverage that best fits your needs. Be sure to indicate the amount of insurance you want and the plan you want: **Employee Only** or **Family Plan**.
    a. Return the form to Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285).

No underwriting information is required. You are **guaranteed coverage** if you are a benefited employee. Consequently, you may apply for Personal Accident Insurance, increase the amount of your coverage, or change plan selection at any time without having to obtain approval from the Life Insurance Company of North America.

Personal Accident Insurance Coverage

Payable benefits are determined by the specific nature of the accidental injury or death in accordance with group policy provisions. In general, the following events are all payable at 100% of the maximum benefit for which the participant is enrolled; however, some lesser combination of these tragic events may be payable at less that 100% of the benefit maximum.

- Loss of life
- Loss of any combination of hands, feet, or eyes,
- Loss of hearing and speech,
- Quadriplegia

For the employee, the maximum benefit amounts to the full amount of coverage elected. For eligible family members, this amounts to a percentage of the employee's elected amount. Please refer to this policy's *Certificate of Insurance* for more detail regarding coverage.

Coverage When Flying

It covers you and your family members while flying (as a passenger only) in any licensed civilian aircraft, or in military transport aircraft operated by Military Airlift Command or similar foreign service. It also covers you while you are serving as a pilot for pleasure purposes only.

Reductions in Coverage

Your coverage is reduced when you reach age 70. Coverage for your spouse terminates when he or she reaches age 70, when your coverage terminates, or when he or she is no longer eligible, whichever occurs first. Coverage for your dependent children terminates when your coverage terminates, or when they no longer qualify as dependents.

Beneficiary Designations

Review your Personal Accident Insurance beneficiaries after any major life event (birth, death, marriage, divorce, etc.) to ensure that the appropriate individuals will receive the insurance benefits in the case of a qualifying event. Contact Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285) to verify or change beneficiaries. *Beneficiary Designation* forms are available on-line at the department's Intranet site: www.csj.gov.

When Coverage Terminates

Coverage will terminate when you leave City employment, cease to be eligible, or fail to remit premium. Coverage for your spouse terminates when he or she reaches age 70 or ceases to qualify as a legal spouse. Child dependent coverage will terminate when they cease to be eligible as a qualified dependent (see the *Eligibility* section above).

Policy Conversion

If you leave City employment before you reach age 70, you may keep this insurance policy by converting your coverage to an individual policy. You pay the premium in effect for your age and occupation as of your last day of employment with the City. Refer to the Personal Accident Insurance *Certificate of Insurance* available from Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285) for more information.

LONG TERM CARE INSURANCE

The City offers long term care (LTC) insurance for all benefited employees who are actively at work. The City's long term care insurance plan covers expenses related to nursing home care, residential care, facility care, and community and home based care, and is designed to help alleviate the financial burdens of participants who suffer the need to utilize these services.

Eligibility

In addition to full-time or part-time benefited employees, an eligible employee's spouse or domestic partner, parents, parents-in-law, grandparents, or grandparents-in-law are eligible to apply for long term care insurance under the City's group policy.

Cost

Employees are responsible for the entire portion of their own and their family members' premiums when taken through bi-weekly payroll deductions. Premiums are based on the level of coverage elected and the participant's attained age at the time of application.

Detailed rate information is available from Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285). Monthly rates are available on-line through the City's custom LTC website (web address and access information cited below). Separate arrangements can be made with Prudential to direct bill for eligible family members if desired.

How to Enroll

Prudential Insurance Company of America administers the City's Long Term Care enrollment process. All applications for enrollment must be submitted to Prudential via mail or on-line when applicable.

- You may order an *Enrollment Kit* on the City of San Jose's custom website:

  Web Address: www.prudential.com/gltc/csj.html

  Group Name: *CSJ*
  Password: *LTC4CSJ*

- Or, you can contact prudential via e-mail or phone:

  E-mail: LTC.4ME@Prudential.com

  Customer Service Center: 1-800-732-0416

Enrollment Conditions

The following enrollment conditions apply for eligible employees and family members:

1. New Hires/ Newly Benefited Employee Applications – All eligible New Hires or newly benefited employees will be guaranteed coverage if they apply within the first 90 days of their initial date of eligibility. These employees are eligible to enroll either on-line or through a hard copy application available in Prudential's *Enrollment Kit*.
2. Late Applications – Employees who chose to enroll after their first 90 days of employment will still be eligible to apply for coverage; however, late applicants will be subject to medical review and approval by Prudential's medical underwriting department.

Please Note: Late applicants must complete Prudential's Enrollment Kit application. Online enrollment is not available for late applicants or eligible family members.

3. Eligible Family Member Applications – Eligible family members may apply at any time, but must submit *Enrollment Kit* application(s) to Prudential. Each applicant will be required to submit a separate application when requesting coverage. Each application is subject to medical review and approval by Prudential's medical underwriting department.

When Coverage Begins

For late applicants and eligible family members, coverage becomes effective beginning on the first day of the month following the month in which your application was approved by Prudential (it usually takes 1 –2 months to obtain approval).

For New Hires and newly benefited applicants, deadlines for processing applications are applicable and may affect your initial date of coverage. Please contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for more information about your effective date of coverage.

Basic Plan Options

	Option I Daily Maximum Benefit	**Option II Daily Maximum Benefit**	**Option III Daily Maximum Benefit**
Nursing Home Care	$100	$150	$200
Assisted Living or Residential Care Facilities	$75	$112.50	$150
Home & Community Based Care	$50	$75	$100
Lifetime Maximum Benefit Options			
Lifetime Maximum - 5 Years	$182,500	$273,750	$365,000
Lifetime Maximum - 10 Years	$365,000	$547,500	$730,000

Optional Plan Features

Automatic Inflation Option – If you elect this option, your benefits will automatically increase by 5% compounded annually while your premiums remain level based on your original issue age. If you do not elect this option, Prudential will offer you opportunities to increase your coverage over time, but the rates for the increase will be based on your attained age.

Cash Benefit Option - If you elect this option, you will receive benefit cash payments equal to the Home & Community Based Care Daily Maximum you elect without having to incur formal expenses. The cash benefits you receive can be used at your own discretion.

Exclusions and Limitations

Benefit Waiting/Elimination Period – Before benefits are payable, you must satisfy a 90 day waiting period. This period is counted in calendar days and begins on the date you contact Prudential to arrange for a claims assessment. This waiting period needs to be satisfied only once during your lifetime.

Pre-Existing Condition Limitation – This limitation applies only to those individuals who are guaranteed coverage without having to satisfy medical evidence (new hires or newly benefited employees). If you have a condition for which medical advice or treatment was recommended or received within six months immediately preceding the effective date of your coverage, you will not be covered for that condition until six months after the effective date of your coverage. Please consult Prudential for questions regarding this limitation (further information is available on the website and in the *Enrollment Kit*).

A complete list of Prudential's exclusions, limitations, and disclosures is available in Prudential's Enrollment Kit. Please order an Enrollment Kit even if you are eligible to enroll on-line.

When Coverage Terminates

Coverage will only terminate for you and your covered family members if you fail to continue to remit your premium. If you allow your coverage to terminate, you will be required to re-apply for coverage by completing an *Enrollment Kit*. Your coverage will be subject to Prudential's underwriting approval. Your premiums will be re-assessed at your attained age at the time you re-apply.

Policy Conversion

If you cease to be eligible as a benefited City employee or separate from City service, you may contact Prudential Insurance Company to request that they bill you directly. Your premium and coverage will not change. You will retain the same plan design afforded to benefited City employees and their eligible family members.

Covered family members may request a direct billing arrangement at any time.

Additional Information

Detailed plan information is available on-line through the City of San Jose's custom website. In addition, the Prudential *Enrollment Kit* contains full plan and disclosure information. To speak with a Prudential customer service representative please call 1-800-732-0416.

Summary plan information and rate sheets are available from Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

DEFERRED COMPENSATION PLAN

This program is a voluntary benefit and provides a convenient way for City employees to save money for retirement. Money is deducted from your payroll check before taxes are taken out (reducing your taxable income) and is invested for you, per your direction through the enrollment process. This program was established under Section 457 of the IRS Code. All City employees are eligible to participate. Once you have invested the money, the law does not allow you to take it out of the program until you retire, terminate employment with the City, die, or experience an unforeseeable financial hardship. (See the upcoming section "Financial Hardship" for more information on that subject.) **This is not a regular savings account.**

Plan Description

The Deferred Compensation Plan is a written agreement between you and the City. It allows you to defer and invest part of your wages, and not pay taxes on this money until you receive the money. At that time, presumably, you will be in a lower tax bracket and will therefore pay less tax on the money than if you received it now in your present tax bracket.

Deferred Compensation Plan Advantages

The program also allows the interest on your invested money to accumulate tax-free until money is distributed to you. This deferral of taxes allows you to invest more money than you could afford to invest if you used after-tax dollars for savings. It also allows the earnings on your investment to accumulate faster than they would if they were taxed in the year they were earned. The complete text of the Deferred Compensation Plan can be found in Chapter 3.48 of the San Jose Municipal Code.

In the long term, this program helps you to:

- Reduce your current tax liability.
- Accumulate more money than is usually possible with after-tax savings methods.
- Supplement your retirement income. This program does not affect your City Retirement System program or contributions in any way. By participating, however, you can supplement the amount of money you will have to spend during retirement.

Investment of Your Deferred Wages

An Advisory Committee manages the investments of deferred wages. This committee establishes contracts with companies offering appropriate investment vehicles. You may request that your money be invested in a particular area. However, the final determination of investment vehicles available at any given time is made at the sole discretion of the Advisory Committee.

Your deferred income is placed in an account established for you with the administrator you have selected. All payroll deductions and interest earnings are credited to your account. All assets are held by the City in trust for the exclusive benefit of the participants and beneficiaries of the plan.

Amount You May Defer

Under federal law, the **maximum** amount that you may defer in calendar year 2006 is $15,000. This **maximum** will increase $500 annually thereafter. Contributions can be 100% of gross compensation or a dollar limit not to exceed the contribution in effect for the current year. The **minimum** amount that you may defer is $25 per pay period.

Pre-Retirement Regular Catch-Up Provision

There is an exception to the maximum limitation rule. During the three (3) years before the year designated as your normal retirement age, you may exceed the maximums described above in order to make up for years when you did not invest the maximum amount for which you were eligible. This is called the Regular Catch-Up Provision.

Catch-Up Rules

Catch-Up Provision rules are as follows:

1. You may defer the difference between what you were eligible to defer and what you actually deferred from January 1, 1979, to the present.

   A calculation is required to determine your eligibility for this provision. Please contact Deferred Compensation in the Employee Services Department (City Hall Wing, 2nd Floor, 975-1465) for further information.

2. Your total annual deferral during the Catch-Up period may not exceed twice the normal annual contribution limit in effect for the current year. The Catch-Up limit for 2006 is $30,000. In 2007 and later the annual maximum will be a cost of living increase in $1,000 increments. This includes the maximum amount you are allowed to defer during the current year, plus your eligible Catch-Up amount.

3. You may begin Regular Catch-Up three years prior to normal retirement age.

Catch-Up Provision for Employees Aged 50+

Individuals who are currently age 50 or older, or who will turn age 50 in the calendar year, may contribute an additional $5,000, for a total of $20,000 for 2006. In 2007 and later the annual maximum will be a cost of living increase in $500 increments. Participants may not use this provision if they are using the above Regular Catch-Up Provision.

Deferred Income Investment Options

You have several choices for investing your deferred income. Contact Deferred Compensation for details. You may transfer your money between investment options and companies at any time.

How to Enroll

Employees have three options for enrollment and may enroll anytime during employment:

1. Enroll on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

2. For individual appointments, brochures and program details, contact Deferred Compensation in the Employee Services Department (City Hall Wing, 2nd Floor, 975-1465).

3. Meet with Provider representatives, who are available in City Hall and certain other locations at scheduled times. Call Deferred Compensation at 975-1465 for the current schedule.

Making Per Paycheck Deferral Changes

Paycheck deferral amounts can be made on-line through the City's Intranet site: www.csj.gov/eway. No paper forms are required.

Payroll check deductions for your deferred compensation will begin according to the IRS "first-of-the-month" rule. The "first-of-the-month" rule requires that a participant, requesting a first time deferral, an increase of deferral or restart of deferral, makes the election before the first of the month in which the deferrals occur. Therefore, elections entered or submitted, between the 1st and last day of the month, will be deferred from paychecks in the following month.

NOTE: If you change your contribution to zero, the first-of-the-month rule does not apply, and the deduction will be effective within two (2) paychecks.

Distribution Options

Under certain circumstances, the value of your account may be distributed to you as you elect. If you leave the City to work for another employer in the State of California who has an eligible 457 deferred compensation plan, you may also elect to transfer your funds to the new employer. See the section on "Pay-Out Options" for more information.

Here are some of the reasons for requesting distribution:

- Death (payment to beneficiary)
- Retirement
- Separation from City service
- Financial hardship (See the upcoming section "Financial Hardship" for more information on this subject.)

Within thirty (30) days following separation from of City employment you must decide how to proceed with your deferred compensation balance. You may not receive funds in the same month that you separate from service.

Determination of Financial Hardship

You may withdraw funds from your deferred compensation account prior to retirement only in some cases of financial hardship. Section 457 of the Internal Revenue Code defines financial hardship as the "occurrence of an unforeseeable emergency" that causes severe financial hardship to you or your dependents and is not covered by other insurance. It also states that financial hardship is not intended to include the use of funds to purchase a home or send children to college.

Financial Hardship Withdrawal

To apply for a hardship withdrawal, obtain a *Financial Hardship Request* form from Deferred Compensation in the Employee Services Department (City Hall Wing, 2nd Floor, 975-1465). Then forward the completed form back to Deferred Compensation.

The completed form will be presented at the next meeting of the City's Deferred Compensation Advisory Committee, which determines whether your application meets the guidelines in comparison to IRS requirements. You may attend that meeting to answer any questions about your request and to provide supplemental information. The committee will vote on the approval of your request at that meeting.

If not satisfied with the Advisory Committee's decision, you may appeal the decision by requesting a new hearing; at that hearing you may present additional information about your need for the withdrawal.

Income Tax Rules

The money you defer, and the income earned on this money, is subject to income tax at the time you receive the money. Under current IRS regulations, distributions from Deferred Compensation **may** be "rolled over" into an IRAs, 403(b), 401(a) and/or 457(b) governmental Deferred Compensation plan.

Pay-Out Options

You may choose to have your benefits paid to you in one or more of the following ways:

- A single lump sum.
- In equal monthly, quarterly, semiannual, or annual installments of $50 or more, over a pre-selected period.
- Cost of Living Adjustment (COLA) option.
- Various lifetime annuity options (see your enroller for details). Fractional Payments.
- Postponement of payments until a future date, not beyond age 70 1/2. After your postponement, you select from the options listed above.

If you do not choose to delay payment, payment of benefits to you may start as soon as thirty-one (31) days after your termination of employment, but no later than sixty (60) days after the end of the calendar year in which you terminate employment.

Post-Retirement Earnings

Your retirement account will continue to earn interest after you retire (unless you choose to withdraw all your money in a lump sum when you retire).

If you choose a "pre-selected period" pay-out, your enroller will calculate the projected growth of your account at anticipated interest rates based on the length of the pay-out period you select. This calculation will be used to establish the amount of the payments you receive from your account. Any excess earnings due to higher-than-anticipated interest returns after your retirement will increase the payment amount you receive.

If you choose a "pre-selected amount" pay-out, the amount of each payment will not change, but the length of the pay-out period may vary. Any excess earnings due to higher-than-anticipated interest returns after retirement will extend the number of payments you receive.

Beneficiary Designations

Remember to review the beneficiary designation on your deferred compensation account after any major life changes. The City's *Beneficiary Designation* form supercedes wills, so keep your designations current at all times.

If you are married and your spouse was not named as beneficiary, your spouse may have community property rights to your account funds unless your spouse signs an acknowledgement that he or she is not a beneficiary.

BENEFITS CONTINUATION DURING LEAVES OF ABSENCE

Paid Leaves of Absence (LOA)

Benefits eligibility is established through regular paycheck premium deductions taken each payperiod. If you are on a paid leave of absence (sick leave, vacation, Workers' Comp case, etc.) and you continue to receive a City paycheck, both yours and the City's contributions will continue to be made on your behalf to the City's respective benefit providers. Consequently, employees on paid leaves of absence do not need to do anything to maintain their benefits eligibility while out on a paid LOA.

Unpaid Leaves of Absence

When you begin an unpaid leave of absence, your City paychecks will cease. Consequently, the employee and City portions (if applicable) will stop. This lack of premium contribution will interrupt your benefits eligibility within both the City's and the benefit providers' systems.

Beginning an Unpaid Leave of Absence

As soon as you anticipate going on unpaid leave (even while on a paid leave of absence) contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for information regarding premium/benefits continuation. Employee Benefits will provide you with information to assist you with continuing your benefits so that you experience no breaks in coverage.

Benefits Continuation Limitations

Some of the City's benefit plans and policies contain provisions for maximum leave periods. Please refer to the *Benefits Continuation Matrix* to identify which benefit plans have maximum leave limitations. You will not be permitted to continue these benefits beyond the maximum LOA period permitted by the City's policies or contracts, regardless of your willingness to continue to remit premium.

Benefits Continuation While on Family and Medical Leave (FMLA)

If you are on an approved Family and Medical Leave leave of absence, you will be entitled to the City's regular contribution to your Health, Dental, Vision (if applicable) and EAP benefit premiums for the 12 weeks of leave allowed by FMLA legislation (See the *Family and Medical Leave (FMLA)* section on page 57).

If you are on paid FMLA leave, your's and the City's premiums will be collected and remitted as usual through your regular paycheck. If and when you begin unpaid FMLA leave, you will be responsible for remitting your portion of your regular premium; the City will continue its portion through the remainder of your 12 weeks of FMLA leave.

Additional Information

Each leave of absence is somewhat different. Please coordinate your leave with an Employee Benefits staff member prior to beginning your leave. More information is available from Employee Benefits in Employee Services (City Hall Wing, 2nd Floor, 535-1285).

TIME OFF: PAID AND UNPAID

HOLIDAYS

All full-time employees are eligible for fourteen (14) paid holidays per year. These holidays are:

New Year's Day	Columbus Day
Dr. Martin Luther King	Veterans' Day
Presidents' Day	Thanksgiving Day and
Cesar Chavez Day	The day after Thanksgiving
Memorial Day	Christmas Eve Day
Independence Day	Christmas Day
Labor Day	New Years Eve Day

Note: City Hall is shut down during the holiday furlough (the days between Christmas and New Years Eve). During the furlough, employees should use vacation or compensatory time in order to be paid.

Holiday pay is calculated by the number of hours for which you are regularly scheduled to work. Specified employees may receive pay in lieu of holiday time off. Holiday dates are published in a City Calendar that is distributed to all employees before the beginning of each year.

VACATION

Employees may take vacation leave after completing thirteen (13) pay periods with the City. After you become eligible to take vacation leave, the total number of vacation hours you may take through the end of that calendar year will appear on your paycheck stub.

Consult your MOA for information about the vacation time that you earn each year that you work for the City and the amount of unused vacation you may carry over at the end of each year. If you leave City employment prior to the end of the year, you may owe the City for vacation hours you have used but not yet earned.

After a period of time, unused vacation time may be lost. A certain number of hours may be carried over from one calendar year to the next. Rules vary for management employees, non-management employees, and public safety employees. Under certain conditions the City Manager may authorize exceptions. Consult the Office of Employee Relations (535-8150) for specific details.

If you work part-time, are on a reduced workweek, or take time off without pay, your vacation accumulation is affected, because vacation time is calculated by the number of hours for which you are paid. Please note that you do not accumulate extra vacation time for overtime hours worked.

PERSONAL LEAVE

Some full-time employees may also take personal leave, subject to supervisor approval. Consult your MOA to learn if you are eligible for Personal Leave.

SICK LEAVE

All full-time employees may take sick leave with pay as medically required. Sick leave is for your injuries or illness, and for your routine health and dental appointments. You may take sick leave to care for a sick dependent. Check your MOA for details.

Paid sick leave accrues at a rate of approximately one (1) hour per twenty-two (22) hours worked up to a maximum of 96 hours per year for most employees. There are no carryover limits. If you work part time, are on a reduced workweek, or take time off without pay, your sick leave accumulation is reduced because sick leave time is calculated based on the number of paid hours. You do not accumulate extra sick leave for working overtime hours.

If you are going to miss work because you are taking sick leave, try to contact your supervisor before your scheduled shift begins. Substantiation (such as a doctor's certificate) may be required for any sick leave.

When you retire after fifteen (15) years of service, or more, you may receive pay for a percentage of your unused sick leave. Check your MOA for more information.

BEREAVEMENT LEAVE

If you are a full-time or part-time benefited City employee, you may be eligible for paid leave in the event of the death a relative.

Your supervisor may request verification for bereavement leave. Bereavement leave for a brother-in-law, sister-in-law, or domestic partner in lieu of a spouse may be authorized in your MOA. If you are not scheduled to work, bereavement leave is not paid. For details, consult your MOA.

JURY DUTY LEAVE

If you serve as a juror you will receive your regular pay; however, you must remit to the City any jury fees paid to you. You may keep your mileage payment.

WITNESS LEAVE

Each person who is required to appear in court by reason of his or her employment with the City will be compensated as follows:

- If the court appearance is during your regular shift, you will receive your regular salary during that time.
- If you must appear in court less than two (2) hours before the beginning of your scheduled shift, you will receive your regular pay for the time spent. In no event will you receive less than 2 hours pay.
- If you must appear in court more than two (2) hours prior to your shift, or on your day off, you will receive two (2) or three (3) hours pay at your regular rate, or the appropriate rate for the hours actually spent, whichever is greater. Check your MOA for details.
- However, witness leave may not be provided to employees who are a party to the action and are in a position adverse to the city. Check your MOA for details.

MILITARY LEAVE

Anyone employed by the City continuously for one (1) year prior to engaging in active military duty is paid regular compensation for up to thirty (30) days following entry into active duty.

FAMILY AND MEDICAL LEAVE (FMLA)

Under the federal Family and Medical Leave Act of 1993, (FMLA) you may be entitled to unpaid leave with the City's portion of your health and dental premiums paid for you **if:**

- You have worked for the City for at least one year, and have at least 1,250 hours of work time (excluding paid leave) in the preceding 12 months; and
- Your leave is for one of the following reasons:
    1. To care for a new child through birth, adoption, or state-enacted foster care; or
    2. To care for a seriously ill child, spouse, or parent who requires hospitalization or continuing treatment by a physician; or
    3. To treat your own serious medical condition which makes you unable to work; and
- You use all of your available sick leave (when applicable) and all of your available personal or executive leave, as part of your FMLA leave.

How to Apply for FMLA Leave

To request FMLA leave, complete the *Family and Medical Leave Application,* and a *Request for Leave of Absence* form. Your Timekeeper has both forms and can assist you. Apply for FMLA leave before your leave begins if possible. FMLA leave will not be approved after the FMLA entitlement period ends (FMLA entitlement period is limited to 12 weeks per year).

How much FMLA Leave can be taken?

The combined total of paid and unpaid leave for family medical leave purposes under the FMLA is limited to twelve (12) weeks per 12-month period.

Pregnancy Leave: FMLA and PDLA

If you are disabled by your pregnancy, by childbirth, or by related medical conditions, you may be eligible for up to sixteen (16) weeks of leave, in addition to your FMLA leave, under the California Pregnancy Disability Leave Act (PDLA). As with any unpaid leave other than FMLA-entitled leave, you must pay the full cost of the health and dental premiums in order to continue your health and dental coverage during leave under the PDLA.

The City's portion of your health and dental premium costs will only be paid during the paid and unpaid portion of your approved FMLA leave. If your department approves unpaid leave beyond your FMLA leave entitlement, you are responsible for the full cost of health and dental premiums (your portion and the City's portion) during this additional leave.

You will be advised in writing of your authorized leave period under the FMLA after review of your application and receipt of the required medical verification.

Medical Verification is Required for FMLA Leave

For FMLA leave, medical verification is required from your health care provider that you are unable to perform the functions of your job or are needed to care for a family member. The FMLA medical verification must contain the following:

- For FMLA leave for your own illness or injury:

  Doctor's certification of your "serious medical condition" as described in the federal Family and Medical Leave Act; the approximate date the medical condition began; the probable duration of the condition; the probable duration of the your inability to work due to the condition; certification that you are unable to perform one or more of the essential functions of your job.

- For FMLA leave to care for an eligible family member:

  Doctor's certification of the same information described above regarding your family member's illness or injury; the doctor's statement that you must be absent from work to care for this family member; your description of the care you will provide; and your estimate of the period during which this care is required for your family member (including your anticipated work schedule if your leave will be taken on an intermittent basis to care for a family member).

Medical verification for FMLA leave must be provided directly to the Return to Work Coordinator, Employee Services, City of San José, 200 E. Santa Clara St., San José, CA 95113. Because this information is confidential, it should not be attached to your *Family and Medical Leave Application.* An optional medical verification form is available from your Timekeeper (or the Employee Services Department) for you and your doctor to use in providing the medical certification required for FMLA leave.

A "Doctor's Note" is generally not sufficient to provide FMLA medical verification. FMLA medical verification is separate from and in addition to any statement or form which may be required for any insurance purpose including a claim for Long Term Disability Insurance provided by The Standard Insurance Company. Leave under the FMLA will not be approved until the FMLA medical verification has been received by Employee Services.

LEAVE OF ABSENCE WITHOUT PAY

You may be able to take a leave of absence without pay subject to the approval of your supervisor, your department head, and the Director of Employee Services. This type of leave may be used for any valid reason, including taking time off to spend with a new baby.

How to Apply

To request a leave of absence, or take more than two weeks off without pay, you must fill out a *Request for Leave of Absence* form, available from your Department Timekeeper. **Note:** A separate application is required when applying for Family and Medical Leave (FMLA).

Insurance while on Unpaid Leave

While you are on any kind of unpaid leave (other than approved Family and Medical Leave under the Family Medical Leave Act of 1993) you must pay for the City's contributions to your health and dental premiums, as well as making your own usual contributions.

While you are on any unpaid leave, including unpaid leave under the Family and Medical Leave Act of 1993, you must pay your own and the City's contributions for any other insurance coverage, such as life insurance or long term disability to continue your coverage. You must pay all of the necessary premiums during any unpaid leave to keep your insurance coverage in effect. The City does not automatically make its contribution to your insurance programs while you are on unpaid leave. If you do not make these payments, your coverage will lapse.

Contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for more information regarding benefits continuation while on unpaid leave.

Vacation, Sick Leave, and Service Credit while on Unpaid Leave of Absence

When you take a leave of absence without pay, the following items, determined by the number of hours you work, are affected as follows:

- Your vacation, sick leaves, retirement service hours, and seniority hour balances cease to accumulate.
- The timing of step increases is delayed.
- Completion of your probation is delayed.

LOA Extensions

Any extension to a leave of absence must be requested in writing prior to the end of your leave.

End Of LOA

Failure to return to work immediately following the end of your approved leave of absence will be considered a voluntary resignation.

SICK LEAVE WITHOUT PAY

Full-time employees may be eligible for up to twelve (12) months of unpaid leave for an absence due to a non-job-related illness, injury, or disability. This is considered *Sick Leave Without Pay*.

See your MOA or Employee Relations for specific limits on the length of sick leave for your position. *Sick Leave Without Pay* is one example of *Leave of Absence Without Pay*, and all *Leave of Absence* procedures are applicable.

RETURNING FROM A LEAVE OF ABSENCE

When you return from a leave of absence, you must complete a *Return from Leave Verification* form and turn it in to your Department Timekeeper. You will not be paid until this form has been completed.

If you have been dropped from any City benefit plans because you did not pay your own premiums during your leave, you may be required to re-enroll upon your return from leave. Coverage will begin again once the appropriate premiums are paid, but no sooner than the first of the month following your return. Please contact Employee Benefits in the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285) for more information.

TIME DONATION PROGRAMS

CATASTROPHIC ILLNESS/INJURY TIME DONATION PROGRAM (CITD)

This provision is designed to assist an employee who has exhausted paid leave time due to the employee's critical medical condition or, depending on the bargaining unit, critical medical condition of an eligible family member. This provision allows other employees to donate time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period of time.

Please refer to your MOA for union-specific requirements. Also, please consult the City Policy Manual (CPM), Section 4.2.10, *Time Donation Programs,* for more details regarding policy and administrative procedures.

Eligibility for CITD

- Medical Eligibility: A qualifying illness or injury would generally be extremely serious, totally incapacitating, and life threatening. Medical eligibility is verified by Employee Health Services, and confidentiality is assured throughout the process. Non-medical staff will not know the nature of the illness without the employee's consent.

- Other Eligibility: In order to qualify for the CITD program, an employee must have exhausted all paid leave **and** been on leave for at least 30 (consecutive or cumulative) calendar days.

Designation of a CITD Liaison

A CITD Liaison is designated for each CITD case. This is a friend or co-worker who will advocate for the employee, and who will provide information about his, or her, condition while respecting the employee's wishes for privacy, and making donation forms available. Donation forms and all correspondence are strictly confidential.

Review By Employee Health Services

Once Employee Health Services has verified the employee's medical qualification, the Employee Services Department will provide an individual *Time Donation* form in the name of the approved CITD recipient for the employee's CITD Liaison. The Employee Services Department will not provide a *Time Donation* form, and donations will not be accepted, until Health Services has approved the CITD case.

How to Make a CITD Donation of Time

You may donate earned vacation or compensatory time to a fellow employee whose CITD case has been approved by completing a *Time Donation* form for that specific employee. After you complete the *Time Donation* form, you may turn it in to either the employee's CITD Liaison or to the Employee Services Department.

You may also make an unspecified donation to the CITD bank. Your donated hours will be converted into sick leave to be used by a CITD recipient.

How CITD Works

Donated time is converted into sick leave to be used by the CITD recipient. Any LTD (salary continuation) benefit paid to the ill or injured employee by the insurance company will be reduced when the employee is using donated time because sick leave is deductible income under the City's LTD policy.

For CITD Donations

Employees who wish to either receive or donate hours under this program may contact the Employee Services Department at 535-1285 for specific information about the Catastrophic Illness Time Donation Program.

PERSONAL ILLNESS/INJURY TIME DONATION PROGRAM (PITD)

This provision is designed to assist an eligible City employee who has exhausted paid leave time due to employee's non-critical medical condition. This provision allows other employees to donate time in accordance with the following terms so an employee may continue in a paid status with the City for a longer period of time.

Eligibility for PITD

- Medical Eligibility: The employee must be absent from work due to a non-job related personal illness or injury that will require more than thirty consecutive calendar days absence. The Employee Services Department shall be provided with medical verification that the employee's condition will require more than thirty consecutive calendar days absence from work. Medical eligibility is verified by Employee Benefits Staff, and confidentiality is assured throughout the process

- Other Eligibility: In order to qualify for the PITD program, an employee must have exhausted all paid leave **<u>and</u>** been on leave for at least 30 (consecutive or cumulative) calendar days for the specific illness or injury.

Designation of a PITD Liaison

A PITD Liaison is designated for each PITD case. This is a friend or co-worker who will advocate for the employee, and who will provide information about his, or her, condition while respecting the employee's wishes for privacy, and making donation forms available. Donation forms and all correspondence are strictly confidential.

Review By Employee Services

Once Employee Services has verified the employee's medical qualification, the Employee Services Department will provide an individual *<u>Time Donation</u>* form in the name of the approved PITD recipient for the employee's PITD Liaison. The Employee Services Department will not provide a *<u>Time Donation</u>* form, and donations will not be accepted, until Employee Services has approved the PITD case.

How to Make a PITD Donation of Time

You may donate earned vacation or compensatory time to a fellow employee whose PITD case has been approved by completing a *Time Donation* form for that specific employee. After you complete the *Time Donation* form, you may turn it in to either the employee's PITD Liaison or to the Employee Services Department.

How PITD Works

Donated time is converted into sick leave to be used by the PITD recipient. Any LTD (salary continuation) benefit paid to the ill or injured employee by the insurance company will be reduced when the employee is using donated time because sick leave is deductible income under the City's LTD policy.

For PITD Donations

Employees who wish to either receive or donate hours under this program may contact the Employee Services Department at 535-1285 for specific information about the Personal Illness Time Donation Program.

CANCER SCREENING RELEASE TIME PROGRAM

The City has implemented a Cancer Screening Release Time Program. The purpose of this program is to allow City of San José Civil Service employees (classified and unclassified) time away from work to receive breast and prostate cancer screening. Because early detection and diagnosis of such cancers can save lives, the goal of the City of San José is to encourage its employees to schedule and receive regular breast and prostate screenings through their health care provider in order to increase the benefits of prompt treatment.

Eligible Employees

Eligible employees include:

- women 40 years of age and over;
- men 50 years of age and over; and
- employees of any age if a screening is recommended by their doctor or physician.

Since partial day absences are not deducted for salaried (FLSA-exempt) employees, this program is not applicable to employees in Unit 99 (Executive Management), CAMP (Unit 21), and AEA (salaried—Unit 4).

Program Summary

Eligible employees will be allowed a period of up to a maximum of three (3) hours of release time to receive breast and prostate cancer screening to the extent that the screening falls within the employee's normal work schedule. Each eligible employee shall be allowed one (1) period of release time per payroll calendar year. Employees are responsible for making their own arrangements for such screenings (appointments, transportation, payment for procedure, etc).

Requests for cancer screening release time must be made in advance and are subject to pre-approval by the employee's supervisor. Release time shall only be taken during an employee's normal and regular work schedule. Release time will not be approved during a time which will result in overtime.

Refer to the Cancer Screening Release Form on the next page ➔

CANCER SCREENING RELEASE TIME FORM

Instructions

1. Release time for cancer screening examinations must be requested in advance of your examination date and is subject to approval by your supervisor. This time will not be considered sick leave.
2. Complete this form and have your supervisor approve your release time.
3. Have your physician / health care provider complete the examination information section or provide you with a doctor's note (doctor's note should contain the information requested under Examination Information.)
4. Return this form to your department timekeeper. Release time will not be given if this form, with your doctor's verification, or a doctor's note is not returned and completed in its entirety.
5. Timekeepers should notify Payroll via the e-mail adjustment process (current period adjustments) each pay period of employees who participate in this program (name and hours taken). Completed forms should remain with the department timekeeper.
6. Additional Cancer Screening Release Time Forms are available on the City's Intranet site.

Time Card Instructions

1. Until further notice, record your release time for Cancer Screening as ***REG*** on your time card (paper timesheets or web-based time entry).
2. Make a notation in the comments section of your timecard or web-based time system stating "*Cancer Screening - _x_ hours Release Time taken*". Employees who utilize the online time card may do the same.

GENERAL INFORMATION

Name ____
(Please print)

Department____________________ Job Title______________________________

Date and Time of Requested Release ________________________________

Employee Signature and Date________________________________

Release Time Approval ______________________________ ______________
Signature of Supervisor Date

EXAMINATION INFORMATION

Physician / Health Care Provider Name ________________________________

Physician / Health Care Provider Telephone Number____________________________

☐ Prostate Cancer Screening

Date and Time
of Examination______________________

☐ Breast Cancer Screening

Verification of Examination ______________________________ ______________
Signature of Physician / Health Care Provider Date

Rev 01/06

WORKERS' COMPENSATION

IT'S THE EMPLOYEE'S RESPONSIBILITY TO REPORT ON-THE-JOB INJURY OR ILLNESS

If you are injured on the job, report it to your supervisors (or the next level in chain of command) immediately. If time could be lost from work, see a physician within 24 hours. California law provides benefits to employees who are injured on the job or contract a job-related illness. Benefits vary with each situation. Keep your supervisor aware of your current status.

What is Workers' Compensation?

California workers' compensation law, passed by the state Legislature more than eighty-five years ago, guarantees prompt, automatic benefits to workers injured on the job.

Who's Covered?

All City employees are covered under workers' compensation law. Unpaid volunteers may not be covered.

What's Covered?

Any injury or illness caused by your job is covered—everything from first-aid type injuries to serious accidents. Job-related illnesses may qualify for workers' compensation coverage as well.

Workers' Compensation Benefits and Payments

For a complete description of workers' compensation benefits and payment information, please consult the "*Facts for Injured Workers*" brochure included with your enrollment materials.

For More Information

Visit Workers Compensation:	Employee Services, Workers' Compensation City of San Jose 200 E. Santa Clara St. San Jose, CA 95113-1905
Or, phone Workers' Compensation:	535-1285

PERSONAL & PROFESSIONAL DEVELOPMENT

TRAINING AND DEVELOPMENT

All City employees are encouraged to take advantage of the training and development opportunities offered by the Training and Development Division of Employee Services. Training classes, include over 200 courses offered in subjects such as Analytical Skills, Career Development, Personal Leadership Skills, City Operations, Citywide Issues, Communication Skills, Investing In Results, Horticulture Skills, Retirement Planning, Safety, Wellness, and Computer Skills. These courses are designed to develop current job skills, to foster career development, and to enable personal well being. To view the training classes and register, visit the City Intranet at www.csj.gov.

Additional training and development opportunities include supervisor training, certificate programs, and an accelerated Associate of Arts degree partnership with City College and Evergreen Valley Community College District. Contact Training and Development at 535-1285 for more information.

EDUCATIONAL REIMBURSEMENT (NON-MANAGEMENT)

This program is intended to encourage employees to further their outside academic, professional, and technical education to enhance career development and performance with the City of San José. The City provides financial assistance to employees who complete educational work that enhances their career development with the City of San José. Full-time and part-time benefited with at least six months of service are eligible to take advantage of this benefit. Consult your union Memorandum of Agreement for specific benefits. Contact your department training liaison or Employee Relations at 535-8150 for current procedures.

EDUCATION BENEFITS FOR MANAGEMENT EMPLOYEES

Management employees also have educational incentive benefits. Details about these benefits are available from Employee Relations, 535-8150.

EMPLOYEE SUGGESTION PROGRAM

The City needs your good ideas and will **pay** you for them! As a City employee, you can submit your ideas for improving City operations. Every idea is fully considered, and all possible costs and benefits of your idea are analyzed.

Employee Suggestion Ideas

If your suggestion is used, you may receive a cash award and/or recognition for your idea. The City is looking for ideas that will:

- Improve operations.
- Cut costs.
- Save time.

- Increase efficiency or productivity.
- Streamline procedures and methods.
- Streamline, combine, or eliminate forms.
- Make better use of materials and equipment.
- Save money on materials and equipment.
- Reduce energy usage or water usage.
- Improve safety conditions.
- Improve morale or working conditions.
- Improve service to the public.

Eligibility

All classified City employees below the level of Division Head, including probationary, provisional and part-time employees, are eligible to participate.

If your suggestion is deemed to be part of your regular job responsibility, you will not be eligible for a cash award, but you will still receive credit for your idea, along with a Certificate of Award from the Mayor and the Suggestion Award Commission.

Most ideas are eligible, but there are a few exceptions. Your suggestion is **not eligible** if it**:**

- Was previously submitted by another employee.
- Is already actively under consideration by management.
- Proposes stricter enforcement of existing rules.
- Must be approved through meet and confer negotiations.
- Has already been in place for over thirty (30) days.
- Is a problem that would be corrected through normal maintenance or housekeeping.
- Proposes costly testing or research.
- Corrects errors on drawings or reports that would normally be corrected.
- Concerns new facilities or programs within the first six (6) months of their operations.
- Involves personal grievances, position reclassification, or salary recommendations.
- Pertains to traffic control on City streets.
- Does not provide a definite benefit to the City.

The Suggestion Award Commission will make the final decision as to whether or not a suggestion is eligible.

Awards

The Suggestion Award Commission determines the appropriate award based on the benefits achieved by implementing the suggestion. The appropriate department recommends an award based on the suggestion's cost savings or general benefits. Awards are based on 3 benefits:

- Tangible: If your suggestion's savings can be measured in money for labor, materials, or equipment, or if it results in increased revenue, you will receive 15% of the first year's measurable savings or increased revenue up to a maximum award of $30,000.

- Intangible: If it is not possible to measure the benefits of your suggestion (such as an improvement in service, working conditions, or general efficiency), then the award ranges from $25 to $100.

- Awards for improvements in safety or medical conditions range from $25 to $100.

How to Develop a Suggestion

Look around you, at your own job and at others. Do you see a way to make the work more efficient, safer, or less costly? Could service to the public be improved? Look at each operation with a fresh point of view.

Break the job down into simple steps. Are there bottlenecks or duplications? Can any steps be simplified, combined, or eliminated to reduce work? Study each detail: What is done? Why? How? When? By whom? What can be improved?

Submit Your Idea for Evaluation

After you have developed your idea, write it up on an Employee Suggestion Form. These forms are available in the City Manager's office, City Hall Tower, 17th Floor.

Describe your idea as fully as possible and include as much supporting information as you can. The more information you give the evaluator, the better your chances for adoption.

Suggestion Evaluation Process

The employee suggestion staff logs in your suggestion and reviews it thoroughly. It is then sent to the proper department for evaluation. The department studies your idea to see if it will work and evaluates both the costs and the benefits of implementing it. It then makes a recommendation to the Suggestion Award Commission on whether or not to use your idea.

If the City adopts your idea for use, the Commission decides on an award for you. After the department has implemented the suggestion, an award check is sent to your department head for presentation to you. A notice of your award is also placed in your permanent employee file.

If the City does not adopt your suggestion, the Commission will provide you with an explanation as to why it is not feasible at the time. Your suggestion will remain active for one year after submission and be may renewed for another year after that. You may resubmit your idea (with additional information) at a later date if you feel it will be more useful at that time.

Additional Information

If you need help developing or writing your suggestion, or have any questions about the program, call or visit the City Manager's Office (City Hall Tower, 17th Floor, 535-8100).

ALTERNATIVE WORK SCHEDULES

ALTERNATIVE WORK SCHEDULE PROGRAM

The Alternative Work Schedule program allows certain employees to request a biweekly work schedule other than the normal schedule of five 8-hour days each week. Applications are available from your Department Timekeeper or the Office of Employee Relations.

An Alternative Work Schedule is subject to approval by the Department Head and Office of Employee Relations, and is intended to be your permanent schedule, although it may be terminated or revised to meet your changing needs or the needs of your work unit. Consult your MOA to see if the Alternative Work Schedule program is available to you.

REDUCED WORK WEEK PROGRAM

All employees except police and fire (sworn) personnel may request a reduced work week for personal or medical reasons. Your department has complete discretion regarding approval unless a documented medical condition is the reason for your reduced work week request.

The City's contribution for premiums for health, dental and life insurance are prorated from the amount contributed for full-time employees, based on the number of work hours scheduled per week under each individual reduced work week agreement. Applications and additional information are available from the Employee Services Department (City Hall Wing, 2nd Floor, 535-1285).

COMMUTE ASSISTANCE PROGRAMS

ECO PASS PROGRAM

What is an Eco Pass?

The Eco Pass is an annual, photo ID pass that entitles eligible City of San Jose employees to ride on any Santa Clara Valley Transportation Authority (VTA) bus or light rail line seven days a week and 24-hours per day at no cost to the employee.

Who is eligible for an Eco Pass?

All full-time and part-time benefited employees of the City of San Jose are eligible for an Eco Pass.

How can I obtain an Eco Pass?

Eligible employees can obtain their Eco Pass card by visiting the VTA's Downtown Customer Service Center.

No appointments are necessary. Walk-in photos are taken at the following location and times:

VTA Downtown Customer Service Center
2 North First Street
San Jose, CA 95110

Monday – Friday:	8:00am – 6:00pm
Saturdays:	9:00am – 3:00pm

During your visit you will be required to furnish a *New Employee Eco Pass Authorization* form provided by the Employee Services Department or other proof of employment. Contact the Transportation Planning Division, (408) 535-3850, if you have questions. Your photo will then be taken by a VTA customer service representative who will have your Eco Pass card sent to your work location in approximately 2 weeks.

How can I replace an Eco Pass?

For the first incident, employees are required to pay a $25.00 fee to replace a lost Eco Pass or a $5.00 fee to replace a stolen pass (when the employee furnishes a copy of a Police report). A $50.00 fee is required to replace a lost or stolen Eco Pass for any subsequent incidents.

Eco Pass Replacement Forms are available in the Employee Services Department or from your Department's Commute Assistant. Employees must send in the appropriate fee to the VTA address on this form. Checks should be made payable to the "Valley Transportation Authority."

COMMUTER CHECK PROGRAM

What are the program goals?

The Commuter Check Program is designed to encourage public transit use by City of San Jose employees. The intended benefits for participating in the program include traffic congestion relief, reduced parking demand, and improved air quality.

How does the program work?

The Commuter Check Program provides employees with a $20 per month transit subsidy for all Bay Area transit services, including:

- Caltrain
- Altamont Commuter Express (ACE)
- BART
- Highway 17 Express Bus
- SMART Bus

Each of the transit organizations listed above will recognize the $30 redeemable voucher when an employee submits it for the purchase of multi-ride or monthly passes. The employee pays $10 for the Commuter Check, but receives a $20 benefit.

The Commuter Check entitles the bearer to a $30 credit towards the purchase of their multi-ride or monthly transit passes.

Who is eligible?

Unlike the Eco Pass Program, the Commuter Check Program is available to all Full and Part-time benefited and unbenefited employees alike.

Where can I purchase a Commuter Check?

You may purchase your Commuter Check at the following location and times:

Department of Transportation
Transportation & Parking Operations Division
San Jose City Hall Tower, First Floor, Window #7

Monday – Friday: 8:00am – 5:00pm

EMERGENCY RIDE HOME PROGRAM

How does the program work?

The Valley Transportation Authority (VTA), through the Eco Pass Program, has an account with the Yellow Checker Cab Company and will pay for an emergency-only ride home for any employee who requests the service the same day he or she used bus or light rail to get to work.

What constitutes an emergency?

Qualifying emergency situations include:

- Illness to the employee or an immediate family member
- Unscheduled overtime requested by a supervisor/ manager

The Emergency Ride Home program may not be used for errands, pre-planned medical appointments, business-related travel, un-authorized overtime, or missed or late transit.

How can employees take advantage of this benefit?

Employees interested in utilizing the Emergency Ride Home program must work with their supervisor or manager to access the benefit:

1. The employee is required to verify for their supervisor/manager that they rode VTA Bus or Light Rail on the day of the request.
2. The employee's supervisor or manager should contact the Department of Transportation's Transportation Planning Division at (408) 535-3850 for an *Emergency Ride Home Voucher* form (to be filled out by the supervisor/manager).
3. It is the supervisor or manager who is responsible for arranging the ride home with the Yellow Checker Cab Company.

For more information about the Emergency Ride Home program, contact the Transportation Planning Division at (408) 535-3850.

ALTERNATIVE TRANSPORTATION OPTIONS

Bike Parking

Secure employee bike parking is available at both the new and old City Halls. Employee bike parking consists of individual bike lockers and an enclosed bike cage. Advance registration is required. To access the employee bike parking facilities, contact John Brazil in the City's Bicyclist & Pedestrian Program at (408) 975-3206.

Vanpooling

The City of San Jose's Commute Assistance Program (CAP) is working with the Enterprise Rideshare Program to offer vanpooling to City employees.

The Enterprise Rideshare Program, a division of Enterprise Rent-A-Car, specializes in leasing full-size vans and mini-vans to groups of co-workers that are tired of the hassle and expense of driving their own cars to work each day. For more information contact the Transportation Planning Division at (408) 535-3850.

PERSONAL BANKING SERVICES

DIRECT DEPOSIT OF PAYCHECKS

All permanent full-time and part-time employees may have their payroll checks automatically deposited into their own bank account through the City's Direct Deposit program. Some of the advantages of direct deposit include:

- No long bank lines
- No possibility of losing your check
- Deposits take place even if you are sick or on vacation.

How Direct Deposit Works

1. Any *Automated Clearing House (ACH)* member bank may be used. The City's Credit Union and nearly all banks are eligible to receive direct deposits. You can sign-up for multiple bank accounts on-line.

2. To start your direct deposit employees have two options:
   a. Sign-up on-line through e-Way on the City's Intranet site at www.csj.gov/eway.
   b. Fill out an *Employee Authorization for Automatic Deposits* form and return it to Payroll with a copy of your bank deposit slip. Direct deposit of your check will begin two (2) pay periods later.

   If you change banks, notify Payroll right away. You must repeat the process to start direct deposit at your new bank.

3. Deposits will be posted to your bank account on the pay day. If your payroll check is directly deposited into the Employees Credit Union, it will be posted on the day you are paid.

4. Although your earnings go directly to the bank, you will receive an earnings and deductions statement with the same information you now receive with your paycheck. Employees can also view and print this information on-line through e-Way on the City's Intranet site at www.csj.gov/eway. Employees can send an e-mail to PayrollSupervisor@sanjoseca.gov to request that paper statements be discontinued.

5. Upon termination of your employment with the City, or during extended leaves of absence, your direct deposits will be cancelled. Any "leave balance payoff" (accrued vacation, compensatory time, and any sick leave pay to which you are entitled) will be paid with a normal City payroll check.

6. If an error is discovered in your pay, a deposit correction may be made within 5 days. If you are underpaid, you will be issued a supplemental payroll check.

7. You may enroll or cancel at any time.

SAN JOSÉ CREDIT UNION

Any full- or part-time City employee, active or retired, and their immediate family members living within the same household, can join the San José Credit Union.

Credit Union Services

For many employees, the Credit Union serves as the single source for all of their deposit account services. Some of the services that the Credit Union offers are as follows:

- Share (Savings) Accounts
- Certificate Accounts
- Share Draft (Checking) Accounts
- Individual Retirement Accounts (IRA's)
- Loans to Go
- Payroll Deduction
- Credit Life & Disability Insurance
- Visa Credit Card
- Visa Check Card
- Automatic Teller Machine (ATM)
- Teller Phone Audio Response
- Group Family Protection Plan
- Auto and Homeowners Insurance

For More Information

Please contact the San José Credit Union directly if you are interested in becoming a member or have any questions regarding available services:

San José Credit Union
140 Asbury Street
San Jose, CA 95110
(408) 294-8800
www.sjcu.org

U.S. SAVINGS BOND PROGRAM

This program allows City employees to save money by purchasing United States Savings Bonds for your children's college education, for an emergency fund, or for your own retirement.

You can sign up to have money withheld from your payroll check to be used to purchase savings bonds. Any full-time City employee may participate in this savings program.

Bonds cost one-half their face value. For example, a $100 bond costs $50. At maturity, it will be worth $100.

Bond Registration

No more than two names can appear on any one bond as owner. You have three options for bond registration (ownership):

1. Single ownership in the name of one adult or one minor.
2. Co-ownership in the names of two people as co-owners. Either person may redeem the bond at any time.
3. Beneficiary, with one person as owner and another person as beneficiary. The beneficiary may redeem the bond only after the death of the owner.

Payroll Deduction Options

To purchase savings bonds, you must first decide how much you want deducted from each payroll check, and which bond denomination you want. The smallest bond available through payroll deduction is the $100 (face value) bond. Other available denominations include $200, $500 and $1,000.

It is not necessary to purchase a bond every payday; you may have deductions in lesser amounts withheld each payday until enough to purchase a bond has been withheld. For example, if you wish to purchase a $100 bond (cost: $50), you may have $5 deducted from your payroll check for ten (10) pay periods, or have $10 deducted from your payroll check for five (5) pay periods, etc.

Contact Payroll (City Hall Tower, 4th Floor, 535-7070) for examples of the various combinations of dollar amounts and time periods you can select to make your bond purchase.

Savings Bond Enrollment

You may sign up for the Savings Bond program at any time in the Payroll Office in the City Hall Tower, 4th Floor. Please allow for two-week processing time. You may call Payroll at 535-7070 if you have questions.